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| **EXHIBIT G - CLAIMS FILE LAYOUT** | | |
|  | | |
| The following fields are requested to be included in the monthly claims detail provided to Lake County and its designated consultant. Any field exclusions must be noted on the Proposal Worksheet. | | |
| **Medical- claims file** | **Rx- claims file** | |
| Plan Code | Plan Code |
| Group or policy number | Group or policy number |
| Subgroup for retiree, active, cobra | Subgroup for retiree, active, cobra |
| Employee ID | Employee ID |
| Employee Name | Employee Name |
| Full time or retiree | Member Number |
| Member Number | Member Name |
| Member Name | Relationship |
| Relationship | Member DOB |
| Member DOB | Member Gender |
| Member Gender | Physician DEA |
| Provider Tax ID | Physician NPI |
| Provider Name | Pharmacy NABP# |
| Provider ZIP | Pharmacy Name |
| Hospital, Ancillary, Professional | Pharmacy Address |
| Provider Specialty | Pharmacy City |
| Network | Pharmacy State |
| Claim # | Network |
| Claim Line # | Script # |
| Place of Service | NDC - 11 |
| DRG | GCN |
| Primary Dx | Drug Name |
| Secondary Dx | Drug Strength |
| Tertiary Dx | Retail/Mail |
| Dx Category | Generic/Brand/OTC |
| CPT/HCPCS/Revenue | Single or Multi-Source (Must Include SSG) |
| Modifier | Formulary |
| ICD9 and 10 Procedure Code | Specialty |
| Service Date | Compound |
| Admit Date | Patent Litigation |
| Discharge Date | Fill Date |
| Paid Date | Paid Date |
| Service Count | Days Supply |
| Billed | Qty |
| Covered | Cost Basis (AWP, MAC, U&C,etc.) |
| Not Covered | AWP |
| Discount | Ingredient Cost |
| Allowed | U&C Amount |
| Copay | Admin Fee |
| Deductible | Dispensing Fee |
| Coinsurance | Sales Tax |
| COB | Total Amount |
| Paid | Copay |
|  | Deductible |
|  | Coinsurance |
|  | Paid |