DRAFT
SUBJECT TO REVISION

OFFICE OF THE CORPORATION COUNSEL POLICY AND PROCEDURE MANUAL

Effective 2002

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A. Mission Statement

The Corporation Counsel serves as the chief legal advisor to and the attorney for the City and all City officers and departments in matters relating to their official duties.

1. The Office of the Corporation Counsel assigns an attorney to every department in the City, and to each of the City's various Boards and Commissions. These attorneys provide legal advice and are responsible for handling all legal transactions that relate to the assigned departments, including but not limited to land disposition agreements, leases, deeds, contracts, etc. Areas of practice include real estate acquisition and finance, economic development, commercial loans, public finance, securities, small business loans, home loans, and real estate closings, tax collections and administrative hearings.

2. The Office maintains a trial practice group that is responsible for the following activities:
   a. Civil litigation and administrative proceedings before all state and federal courts and agencies.
   b. Areas of practice include personal injury, wrongful death, civil rights (including excessive force and false arrest), education law, constitutional law, tax appeals, foreclosures, real property, zoning, landlord/tenant, commercial law, labor, personnel & employment law, workers compensation and environmental law.

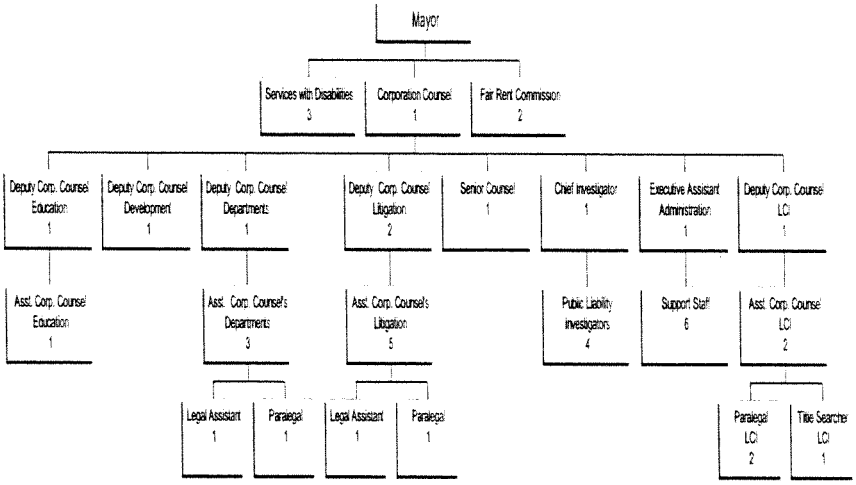
3. In addition, the Office is responsible for the following activities:
   a. Coordinate and manage activities of law firms retained on behalf of the City and City employees.
   b. Coordinate all claims covered by the City's Self-Protected Insurance Program with Coregis, together with the Controller's office.
   c. Pursue collection claims against: third parties who cause damage to City-owned property; seek reimbursement of false alarm fines.
   d. Review, record and respond to complex Freedom of Information (FOI) Requests received by City departments.
   e. Represent the Assessor in defending all real and personal property tax appeals.
   f. Negotiate and draft necessary documentation for complex development projects and other related transactions on behalf of the City.
   g. Issue legal opinions for various City departments.

h. Represent all City Boards and Commissions in various aspects of municipal business and litigation.

4. The Office of the Corporation Counsel also has administrative and coordinating responsibilities for the Fair Rent Commission and Department of Services for Persons with Disabilities.

B. Organizational Chart

The following is an Organizational Chart of the Office of the Corporation Counsel:



C. Attorneys Appointments

The Corporation Counsel is appointed by the Mayor to a term coterminous with the Mayor's term. Each Deputy Corporation Counsel or Assistant Corporation Counsel is appointed by the Mayor to a term of one (1) year commencing in February.

D. Attorney Assignment for Each Term

The Corporation Counsel shall publish a list of attorney assignments, including all responsible areas of law and assigned departments, every term.

E. Special Projects

1. **City-Wide Policy and Procedures Manual**
   This Office, with the Chief Administrator, shall compile a CityWide Policy and Procedures Manual. The Manual shall set forth all written policies, procedures and guidelines for each Department of the City. The cooperation and participation of all attorneys are expected.

2. **Risk Management Strategy**
   This Office shall assist the Office of Management and Budget and the Controller's Office to establish a Risk Management Strategy for the City of New Haven.

3. **Development of a Streamlined Contract/Legal Opinion Procedure**
   The Office of the Corporation Counsel shall impose and adhere to a two-week turnaround time for processing all contracts and legal opinions.

4. **Worker's Compensation Program**
   Effective March 1, 1996, CIRMA handles all of the City's Worker's Compensation cases.

5. **Protected Self Insured Program**
   Effective July 1, 1998, Marshall & Sterling, Inc., authorized agent for Coregis Insurance Organizations insures all claims and lawsuits involving City property and public officials.

F. Office Meetings

1. The Corporation Counsel shall announce all Office meetings.
2. The Corporation Counsel shall announce all Attorneys' meetings.
3. Deputies' meetings are held Mondays at 1:30 p.m., absent changes due to a conflict.'
4. Trial Attorneys' meetings are held Wednesdays at 8:45 a.m., absent changes due to a conflict.
5. Meetings of Attorneys assigned to Livable City Initiative Bureau are held Mondays at 3:00 p.m., absent changes due to a conflict.
6. All support staff (including paralegal and legal assistants) meetings shall be announced and conducted by the Executive Assistant to the Corporation Counsel.

G. Ethical Standards

The Office of the Corporation Counsel of the City of New Haven subscribes fully to the Ethical Principles of the American Bar Association.

1. Conflict of Interest

Neither the Office of the Corporation Counsel, the City of New Haven, nor its employees should do anything that might be construed as compromising the City's professional integrity. When a potential conflict of interest, or the reasonable appearance of one, cannot be avoided, employees can best protect themselves and the City of New Haven, by disclosing the circumstances to the Corporation Counsel and/or the Board of Ethics without delay.

Those employees who make purchasing and contracting decisions for the City of New Haven have a responsibility to the City for independent and objective judgment that must not be compromised.

2. Confidentiality

All Corporation Counsel staff members are to respect the confidence conferred by the Mayor, other city officials, individuals represented by this office, and citizens. This professional relationship demands that there be no disclosure of any information about projects without proper authorization. This includes responses to inquiries about projects or potential projects from the press, contractors, other professionals or the public without proper authorization. Similar respect should be given to our relationships with professional consultants. Assistant Corporation Counsel and staff must consult the Corporation Counsel or any Deputy Corporation Counsel prior to disclosing any information.

All office members share responsibility for maintaining confidentiality, and are responsible for being attentive to their surroundings and maintaining paper and computer files and records in a way that does not expose them to unintended breaches of confidentiality.

H. Indemnification of Employees

In the event a claim is made against any employee of the city of New Haven for work performed within the scope of his or her duties as a employee, the city of New Haven shall indemnify and defend any claim on his or her behalf, providing it is not established that the acts or omissions were willful, reckless, intentional, done with malice, or outside the scope of the employee's terms of employment.

A. Equal Employment Opportunity

It is the policy of the City of New Haven to provide equal employment opportunity without regard to race, sex, age, disability, blindness, religion, national origin or marital status.

This policy applies to all areas of employment, including recruitment, hiring, training, development, promotion, termination, layoff, compensation, and all other conditions and privileges of employment in accordance with applicable federal, state, and local laws. It is also the policy of the City of New Haven to treat all employees with respect and dignity, and to provide an environment free of harassment.

The Department of Human Resources handles the employee classification and evaluation systems that are designed to further the principle of equal employment opportunity. Decisions are based solely on the performance, skills, and potential of the employee.

The City of New Haven is fully committed to this concept and expects its employees to share its commitment to the principles of equal employment opportunity. Any employee involved in discriminatory practices is subject to discipline and/ or discharge.

B. Sexual Harassment

Employees who have complaints of sexual harassment should report such conduct immediately. Complaints should be made to any of the following: the Human Resource Administrator, the Department Head or high level of management. Employees are not required to go through their department heads to make a complaint of sexual harassment. All complaints shall be investigated in a confidential manner. When investigation confirms the allegations, prompt corrective action shall be taken.

C. Orientation

On the first day of employment, or thereabouts, new employees will attend an orientation session conducted by the Human Resources Department, to become familiar with the City of New Haven's benefits, policies and procedures. The immediate supervisor of Assistant Corporation Counsel shall meet with the new employee to review his or her job description and responsibilities, provide instruction for departmental procedures, and ensure that the new employee has all the necessary tools and equipment to begin work.

D. Personnel Files

The Corporation Counsel maintains a personnel file on each staff member. The contents of these files are strictly confidential and are kept for administrative purposes; however, you may ask to inspect the contents of your own file at any time during the business day. Employees will be notified of any correspondence that is placed in his or her file.

A. Pay Period

All Corporation Counsel employees are paid by check on a weekly basis. The Payroll Office distributes paychecks every Friday morning. Arrangements may be made with the Payroll Office for direct deposit of paychecks into the lending institution and account of your choice. Requests for advance vacation pay and early check release (excluding direct deposit recipients) must be made in writing to the Payroll Office in advance, by no later than the Tuesday proceeding the week as to which the check is requested. Any other specific requests should be made directly to the Payroll Office.

B. Attendance

In accordance with the City's Payroll Policies and Procedures, the Executive Assistant to the Corporation Counsel or other designated person will collect, maintain and enter all time for paid interns, overtime of eligible employees, absences, and removal from Payroll (during vacation or leave from the City) on Munis.

C. Overtime & Compensatory Time

Overtime is defined as actual hours worked in excess of forty (40) hours during a regular workweek, or any hours worked in an employee's sixth or seventh day of the workweek, whether or not an employee has worked 40 hours, or any hours worked in excess of eight (8) hours in any day. All personnel not exempt by reason of assignment of duties or salary level will be paid time and one-half for authorized overtime in excess of 40 hours worked during the regular workweek.

Compensatory time off is awarded to those employees not eligible for overtime, but that do meet criteria under the applicable Collective Bargaining Union Agreements at the rate of time and one-half for all hours actually worked in excess of forty (40) hours in the regular workweek.

Pre-approval by the Corporation Counsel and in compliance with the applicable Collective Bargaining Union Agreements must be sought in order to receive overtime or compensatory time off.

A. Normal Work Hours

Each Corporation Counsel staff member is expected to work a regular workweek of 35 hours, exclusive of breaks and lunches.

B. Flex Time

The normal business hours are from 9:00 a.m. to 5:00 p.m., Monday through Friday. Each Corporation Counsel staff member will work thirty-five (35) hours per week. Unless otherwise pre-approved by the Corporation Counsel and in compliance with the applicable Collective Bargaining Union Agreements, there is generally no flextime.

C. Absence and Tardiness

An employee who is or will be absent from work due to illness or some other reason is required to telephone the Corporation Counsel or some other designated person before 9:00 a.m. on the day of the absence. If the absence continues, daily notification should continue throughout the absence.

Employees who are going to be late are requested to notify the Corporation Counsel or some other designated person of the expected time of arrival.

Absence and tardiness are to be so noted on the In/Out Log provided at the Reception Desk. Employees who are chronically absent or late will be subject to disciplinary action.

D. Absence During Work Hours

All Corporation Counsel employees are required to advise the Corporation Counsel when they plan to be absent from the office during the workday. Such requested should be submitted at the earliest possible time, and are subject to denial should the office's business require it. Each employee is required to complete and sign an Absent Report form. A supervisor must sign it, where applicable, and submitted to the Corporation Counsel. Employees are required to sign out at the Reception Desk indicating where they can be reached and when they are expected to return. Upon returning, they should sign in with the Receptionist.

As a courtesy, it is also requested that employees inform their attorney or secretary of their absences. This courtesy helps the office operate more efficiently.

E. Office Equipment

1. Smoking Policy

In recognition of the U.S. Surgeon General's statement regarding the effects of smoking upon both smokers and non-smoker, the Office of the Corporation Counsel is a non-smoking office. No smoking is allowed in restrooms, stairwells or other private areas on the fourth floor.

Ash cans are provided outside the side entrance to City Hall for those employees who wish to smoke.

2. Conference Room

The Office of the Corporation Counsel has two (2) Conference Rooms. Both conference rooms are available on a reservation basis for the purpose of conducting meetings, depositions, etc. and must be schedule in advance with the Receptionist.

The conference rooms shall be vacated prior to the next scheduled conference, and users are responsible for removing any items related to their meeting. As a courtesy, users should also remove coffee cups, soft drink containers, return chairs neatly around the table, etc., before the next meeting. The person responsible for the meeting is responsible for the clean up.

3. Lunch Area

A lunchroom is available to all Corporation Counsel employees. It is expected that each individual clean up after himself or herself so all eating areas are left clean and presentable.

4. Microwave Oven, Toaster Oven and Refrigerators

A microwave over, toaster oven and two (2) refrigerators have been provided for the convenience of all staff members. These areas must be kept clean and orderly at all times. All perishable refrigerator items will be removed each Friday, unless their owner and the (unexpired) expiration date are identified on the item.

5. **Parking**

In New Haven, parking spaces are available in the City Hall parking garage, Ninth Square parking garage, Temple Street garage, and several street-level parking lots. The Mayor's office can be contacted for further information.

6. **Security**

Although this Office serves the public, it is not a public area that is open to the general public. Confidentiality requires that access to the interior of this Office be restricted to office members, those having business in the office, and to limited extent guests of office members.

The office doors are locked from 5:30 p.m. to 8:30 a.m. From 8:30 a.m. to 5:30 p.m., office members are expected to be aware of visitors and guests. Staff members requiring access to the office during other hours and who do not have a cardkey to the office should make arrangement with the security officers. Our offices are protected by a security alarm system. Those employees with cardkeys to the elevators and doors are assigned codes which enable access at all times and said employees are responsible for proper operation of the security system.

7. **Safety**

A First Aid Kit is located in the Lunchroom and is maintained by the Executive Assistant to the Corporation Counsel.

8. **Dress Code**

Although there is no formal dress code for the Office of the Corporation Counsel, it is expected that the attire of all employees shall be neat, clean, and professional.

F. <u>Services & Equipment</u>

1. **Mail & Correspondence**

a. **Outgoing Mail**

An important aspect of the Office of the Corporation Counsel is projected by the quality of its correspondence. It is important that all letters be well written, grammatically

correct and concise. Secretaries are responsible for typing all forms and correspondence in the established format, which is not to be altered by individual staff members. It is the responsibility of the writer to review typed material for accuracy of content. All outgoing mail must be placed in the designated area to be picked up by the City's Central Mailroom staff no later than 3:00 p.m. each day. Any mail requiring express delivery shall be prepared by the secretary and give to the Receptionist to call the vendor for pickup.

b. **Incoming Mail**

All incoming mail such as the Interoffice mail received by the City's Central Mailroom staff and the outside mail to be retrieved from the Mayor's office is sorted, stamped (where required) and distributed as quickly as possible by the Receptionist. Incoming personal or confidential mail that is clearly identified as such is not being opened prior to distribution.

2. **Telephones**

Good telephone procedures and manners are important since they are often the way in which an outsider becomes acquainted with the Office of the Corporation Counsel and/or the City-and, sometimes, are the only exposure someone may have. Courteous, prompt message taking and no long waits on "hold" promote the image of this Office as an efficient business operation.

Personal phone calls restrict the use of the office phone lines for business purposes. Staff members are asked to cooperate by terminating personal calls quickly as possible and to limit their number. Long-distance personal calls are not permitted.

Employees should give out their direct inward dial number whenever possible instead of giving the main phone number. All City numbers start with the prefix 946 and then the employee's extension. When calls come in from outside and the employee is not at the extension, the calls go to their voicemail. People calling in on the weekends and after hours should not use the main number to avoid being placed into voicemail.

Instructions for using the phone system are provided to each employee. All requests for repairs should be directed to the Executive Assistant to the Corporation Counsel. Questions on the mechanics of operating the system and requests for new phones,

moving phones, etc. should also be directed to the Executive Assistant of the Corporation Counsel.

Please notify the Receptionist when you will out of the office or when you will be in conference and do not wish to accept telephone calls.

3. **Visitors**

All visitors (and vendors) are required to report to the Receptionist, who will notify the staff members being called upon. This control is necessary to prevent unauthorized persons from entering the office and facilitate meetings with visitors with a minimum of disruption to normal office activity. Meetings with visitors are to be held in the conference room or private offices but not in the lobby or other work areas. While visitors are in a conference room, the doors should be closed so that neither the visitor nor others in the office inconvenience one another, and to minimize the possibility of someone overhearing a conversation that is intended to be private or confidential. Notifying the Receptionist in advance that a visitor is expected will facilitate providing for him or her in the most professional and efficient manner.

4. **Solicitations**

The City of New Haven permits only one general charity solicitation drive and all staff members are encouraged to participate in this annual fund drive.

5. **Supplies**

The Corporation Counsel must approve all purchases of supplies, materials and equipment. The Purchasing Department issues purchase order numbers upon request of the proper forms. Supplies should be used efficiently. A variety of supplies are located in the cabinets located in the conference rooms. If supplies are nearly exhausted, please notify the Receptionist.

6. **Copying/Printing**

A Copier and printers are provided for the use of all Corporation Counsel employees. Please report any problems or lack of supplies with this equipment immediately to the Executive Assistant to the Corporation Counsel or the Receptionist. It is an expected courtesy to replenish paper supplies and reset settings.

7. **Facsimile**

The facsimile machine is provided for the use of all Corporation Counsel employees. Please report any problems or lack of supplies with this machine immediately to the Executive Assistant to the Corporation Counsel of the Receptionist. Facsimile transmissions may also be completed directly through the use of your desktop computer.

8. **Shredder**

A shredder is provided for the use of all Corporation Counsel employees. All materials waiting to be shredded must be deposited in the container located next to the shredder in the copy room. For those materials that do not fit in the container, they must be deposited in a box, clearly marked with instructions and placed next to the container.

9. **Computer Desktops/Scanner/Laptops**

Computer desktops and a scanner are provided for the use of all Corporation Counsel employees. A laptop is provided for the use of Corporation Counsel. Strict adherence to the City's Computer Hardware and Software Policy is expected by all employees.

10. **Internet Access**

Access to the Internet through MSN for City business is provided for the use of many Corporation Counsel employees. Strict adherence to the City's Internet Access Policy is expected by all employees.

All interns and part-time personnel of the Corporation Counsel must use one of three unassigned computers currently located in the middle of the office and/or in the law library. If all three unassigned computers are in use, permission to us an assigned computer must be given by the Corporation Counsel or Deputy Corporation Counsel.

11. **Cell phones and Cameras**

A cell phone is assigned to the Corporation Counsel, to each Deputy Corporation Counsel, and to each Investigator for City business during the workday. Additional cell phones are kept at the Reception area for use by any office member leaving the office and/or using a city vehicle. These cell phones must be signed-out

at the Reception area. Please report any problems with the cell phones immediately to the Chief Investigator

This Office has purchased several cameras for the use of all Investigators. All cameras must be signed-out at the Chief Investigator's office. Please report any problems with the cameras immediately to the Chief Investigator.

12. **City Vehicles**

There are several City vehicles assigned to this Office for the use of all Corporation Counsel employees. All City vehicles are kept in the City parking lot located on State Street. Strict adherence to the City's Vehicle Use Policy is expected by all employees who wish to use a City vehicle. All City vehicles must be signed-out at the Reception area. All City Vehicles must be returned to the City parking lot with enough fuel for the next user. Fuel is obtained at the Public Works Department located on Middletown Avenue. Please report any problems with the City vehicles to the Chief Investigator.

A. Vacation

Vacation time is earned and credited to each employee's account at the beginning of each calendar year according to the applicable Collective Bargaining Union Agreement, Executive and Professional Agreement, as well as the Personnel and Civil Service Rules and Regulations.

B. Personal Time

The City of New Haven recognizes the need for personal time off to take care of various items that cannot be performed after hours. Refer to the City's Personnel and Civil Rules and Regulations and/or the applicable Collective Bargaining Union Agreement for Executive and Professional Agreement for further information concerning the number of earned personal days per year as it varies according to each agreement.

C. Holidays

The City of New Haven observes the following paid holidays for full-time employees:

NEW YEAR'S DAY
MARTIN LUTHER KING'S BIRTHDAY
PRESIDENT'S DAY
GOOD FRIDAY
MEMORIAL DAY
INDEPENDENCE DAY
LABOR DAY
COLUMBUS DAY
VERTERAN'S DAY
THANKSGIVING DAY
CHRISTMAS DAY
FLOATER HOLIDAY

Please refer to the Observance List distributed by the Human Resources Department each year.

Employee shall receive one (1) floater holiday for use on one of the following days: the day after New Year's Day, the day after Easter, the day before or after Independence Day, Rosh Hashanah, Yom Kippur, the day after Thanksgiving, the day before or after Christmas, the day before New Year's Day, or the employee's birthday. The floater holiday must be identified before August 1.

D. Family and Medical Leave Act of 1993 (FMLA)

The FMLA and the Connecticut General Status, Sec. 31-51cc-gg require employer with more than 50 employee within a 75 mile radius to grant unpaid leave of absences to qualified workers incase of birth or adoption of child, or serious health condition of child, spouse, parent, of the employee. Refer to the FMLA Handbook located in the office of the Executive Assistant to Corporation Counsel or the Human Resources Department.

E. Sick Time

Sick time is earned and credited to each employee's account either every month or at the beginning of each calendar year in accordance with the applicable Collective Bargaining Union Agreement, Executive and Professional Agreement, as well as the Personnel and Civil Service Rules and Regulations.

F. Jury Duty

Employee must immediately notify the Corporation when called for jury duty. Unless circumstances dictate that an employee be excused from jury duty, that individual is expected to perform that duty as a citizen in the community.

Please contact the Human Resources Department for information pertaining to compensation while on jury duty.

Employee must return to the office when their presence is not required during jury duty and immediately upon final termination of jury duty.

G. Bereavement Leave

It is the policy of the City of New Haven to allow paid time away from work according to the terms set forth in the applicable Collective Bargaining Union Agreement, Executive and Professional Agreement, as well as the Personnel and Civil Service Rules and Regulations.

H. Voting

Employees eligible to vote are encouraged to do so on Election Day. Paid time off for voting is local, state or national elections will be given.

A. Health Benefits

The Medical Benefits Division of the Controller's Office coordinates all health and medical benefits for all City employees, retirees and their dependents. This division is located at 200 Orange Street on the third floor.

B. Life Insurance

The Medical Benefits Division of the Controller's Office coordinates all life insurance benefits for all City employees, retirees and their dependents. This division is located at 200 Orange Street on the third floor.

C. Retirement Plans

The Pension Division of the Controller's Office administers all pension benefits for all terminated and retired City employees. This division is located at 200 Orange Street on the third floor.

D. Accident and Cancer Insurance Plan

The City of New Haven offers Accident and Cancer Insurance coverage through AFLAC. This insurance plan is coordinated through the Medical Benefits Division of the Controller's Office. This division is located at 200 Orange Street on the third floor.

E. Deferred Compensation Plans

The city of New Haven offers several 457 Tax Deferred Compensation plans through authorized providers. These plans are coordinated through the Payroll Division of the Controller's Office. This division is located at 200 Orange Street on the fourth floor.

A. Travel

Upon approval by the Corporation Counsel, employees may be reimbursed for expenses incurred while traveling or otherwise performing services for the City. Expenses to be reimbursed include, travel, parking as personal mileage, and other similar direct expenses. All items must be reported on the Expense Report form or Mileage Reimbursement form. Receipts attached to these forms must support all reimbursable expenses. Please use judgment and moderation.

Effective January 7, 1998, the City of New Haven instituted a CityWide Travel policy as follows:

1. Travel Requests

The City of New Haven's "Request for Conference Attendance and Expense Report" form must be completed:

a. General fund requests must be approved by department head and department head coordinator and sent to the Accounts Payable Division of the Controller's Office at least two weeks before the departure date. Should separate checks be required for earlier payments for hotel accommodations or travel, then separate payment vouchers must include the appropriate copy of request to the Office of Management and Budget so that it will be included in the City's Monthly Budget Report submitted to the Board of Aldermen.

b. Special fund requests must be approved by the department head and department head coordinator and sent to the Management & Budget Office prior to their submittal to the Controller's Office, at least three weeks before the departure date. All guidelines established for General fund requests will also pertain to Special fund requests. The Management & Budget Office will include such requests in the City's Monthly Budget Report submitted to the Board of Aldermen.

c. All travel requests must be pre-authorized by said personnel and properly submitted according to the following guidelines prior to the requestor's final commitment or departure. It is not necessary to request an advance of funds. However, subsequent reimbursements will follow the same guidelines and procedures set forth in this policy.

2. Guidelines

a. Registration Fees

All conference or meeting fees must be indicated. In addition, a copy of conference announcement, brochure, registration for, etc. must be attached to the requests so that this amount is verified. Should there by any supplemental registration requests for additional events to be attended, these requests are indicated in the miscellaneous section of the request form.

b. Transportation

Transportation advances are approved as per the employee's Collective Bargaining Agreement or Executive and Professional Agreement. Generally, travel more than 250 miles must be by mass transportation, such as a train, bus or plane. A copy of the bill from the travel agent, bus, or train brochure must be attached to said travel request form. The requestor is required to demonstrate diligence in securing lowest airfare and must submit written explanation demonstrating solicitation of at least three vendors. Personal vehicles may be used in travel less than 250 miles (one way). Advances are made based on destination miles and rate of mile reimbursement. Please refer to the applicable Collective Bargaining Agreement or Executive and Professional Agreement for rates of miles. Please be sure to record odometer reading at the beginning of trip since a completed Mileage Reimbursement form showing beginning and ending mileage is included with Expense Report submitted to the Accounts Payable Division of the Controller's Office.

c. Lodging

Most conferences will include a list of hotels available for said conference. Employees are required to secure accommodations based on proximity to conference and cost. The conference brochure indicating hotel accommodation cost or hotel registration form must be attached to the Travel Request form in order to receive lodging advance. Whenever possible, the City would like multiple requestors attending the same conference to share rooms.

d. **Meals**

Meals are advanced at the following rates: $4.00 for breakfast, $6.00 for lunch and $12.00 for dinner. The City will advance a greater amount for a specific meal should conference include supplemental lunch or dinner engagements exceeding said amounts. The requestor must specifically indicate extras in the miscellaneous section of the form. The conference brochure must indicate this event in order to receive advance.

e. **Gratuities**

Advance request can not exceed 15% of total meal request.

f. **Taxis and Carfare**

Normally, advances do not exceed $10.oo per day. Multiple requestors attending the same conference are required to share this advance through a single requestor. Upon return, requestor is required to submit receipts when submitting the Expense Report to Accounts Payable.

g. **Garaging & Parking**

Advanced to the day traveler at a reasonable amount. Upon return, requestor is required to submit receipts when submitting the Expense Report to Accounts Payable.

h. **Miscellaneous**

Advances in this section require written detail and any brochures or conference forms that show the requested cost.

3. **Expense Reports & Receipts**

The City's Travel Policy requires that a completed Expense Report be submitted to the Accounts Payable Division within 10 days of return. Should expenses exceed original advance, requestor can receive additional reimbursement for registration, transportation, lodging, taxis and certain miscellaneous items. All expense amounts need receipts when applicable. If an additional payment is necessary, the requestor must submit an invoice with the Expense Report to Accounts Payable.

4. **Overpayments**

In some cases, the requestor will owe an amount back to the City. A copy of the Expense Report and receipts with a check in the amount owed to the City, payable to "Treasurer, City of New

Haven" must be submitted to Accounts Payable within 10 days of return.

5. **Denials**

Non compliance of the Travel Policy regarding subsequent Travel Expense Report may result in future denials of Travel Request.

6. **Audits**

General fund Travel Request forms and invoices are audited and paid by the Accounts Payable Division. Capital Project and Special fund Travel Request forms and invoices are audited by Accounts Payable and then submitted to Accounting for payment. Special fund related travel requests are audited and paid by Special funds. Should you have any questions, please call the related division.

B. Official City Vehicle Use

Effective April 4, 2000, the City of New Haven implemented a City Owned Vehicle Policy defining the usage parameters relating to the operation of City of New Haven vehicles by City employees. Refer to the City policy for more information.

1. **Travel and Reimbursement**

In any case where travel is required in order to provide an approved City service, the employee shall be either furnished with a City vehicle or reimbursed for such use.

Any job-related travel by an employee shall be performed by either public transportation, or City-owned or leased vehicle, or by personal car covered by insurance that names the City as an additional named insured. Such certificate shall contain a provision that the City shall be notified upon policy termination.

2. **Local Travel**

Employees in a position requiring local travel as part of the job assignment shall be shall be prepared to use a personal car for such travel and shall receive a mileage reimbursement as necessary. To the extent that City vehicles are available for local travel, any employee in a position that requires regular local travel will be assigned a City vehicle.

3. **Reimbursement Rate**

Reimbursement for the use of private vehicles for authorized City travel is specified in the applicable Collective Bargaining Agreement or Executive and Professional Agreement. Employees who are actively required to drive their personal vehicle on City business must provide the Controller with a certification of insurance providing for $100,000/$300.000 limits naming the City as an additional named insured party. Each person so required shall present a copy of such additional cost and shall be reimbursed as provided.

4. **Out of State Travel**

All requests for travel on City business out of state must be made in advance on the forms provided by the Controller's Office, and must be pre-approved by the department head.

A. Occupational Taxes

Attorney's employed by the City are exempt from being charged Connecticut Occupational Tax.

B. Memberships

The City of New Haven pays for membership in one (1) professional organization or bar association for the period the City employs an attorney.

C. Educational Costs

The City does not compensate/reimburse mayoral appointed employees for costs associated with for credit classwork/certification. Union employees are compensated as provided for in the applicable Collective Bargaining Agreement.

D. Professional Meetings/Seminars

The City upon pre-approval pays Professional meetings or seminars by the Corporation Counsel.

E. Notary Public

Certification to become a Notary Public is paid for by the City upon request of the Corporation Counsel for the period an individual is employed by the City.

A. Purchasing Policies and Procedures

Effective July 1, 1998, the Controller's Office implemented the City's Munis Financial System and Payment Policies and Procedures. The Purchasing Department amended these policies and procedures in accordance with Ordinance Section 2-151 effective July 1, 2001.

The purchasing procedures have remained decentralized at the department level, allowing the departments to manage the purchasing function effectively while complying with the requirements of the City Charter. The Munis Financial System allows the department to electronically submit invoices, purchase requisitions, budget reports and payroll proof lists to the appropriate departments.

Any questions about these procedures and/or recent changes should be directed to the Purchasing Department.

B. The Budget Process

Every year, the Office of the Corporation Counsel has the opportunity to submit requests for funds as part of the General fund and Capital Projects fund budgeting process. A requirement package is circulated sometime in October of each year, for the following fiscal year beginning each July. Department preparation of the budget includes spreadsheet development and narrative development in addition to presentations at the Annual Budget Workshop held every May before the Finance Committee of the New Haven Board of Aldermen.

Any questions about these procedures should be directed to Management and Budget Office.

C. Cash and Check Request Procedures

1. Filing Fee Requests

When the City initiates an action in any court, a fee must be paid to the Court. The Treasurer maintains a special checking account for this purpose. The Office of the Corporation Counsel must authorize checks from this account and must ensure that the sufficient funds exist to cover any checks requested. The Executive Assistant to the Corporation Counsel submits a memorandum to Accounts Payable, usually every quarter, not to exceed the budgeted amount.

A Filing Fee Request form must be completed by the requestor (usually an attorney) and submitted to the Executive Assistant to the Corporation Counsel. This form provides the Controller's Office with the correct payee name, the name of the case and the amount. This form is faxed or delivered to the Controller's Office. The Controller's staff calls when the check is ready for pick-up. Upon pick-up, a copy of the request with the check is made for the file. All checks must be countersigned by the Corporation Counsel or designated Deputy Corporation Counsel.

Any questions about these procedures should be directed to the Controller's Office.

2. **Check Disbursement Procedure**

All Check disbursement relating to settlements or judgments must be submitted to the designated individual for processing.

Vendor checks are usually mailed directly from Accounts Payable. Once issued, all settlement checks and judgment checks are held at Accounts Payable for pick-up by this Office. Checks are issued every Friday. Do not expect a check for at least two to three weeks.

The Executive Assistant of the Corporation Counsel is the keeper of all settlement checks and judgment checks. The checks are kept in the office safe located in the office of the Executive Assistant of the Corporation Counsel. In order to release a settlement check, you must submit a copy of the Release and Withdrawal to the Executive Assistant of the Corporation Counsel. In order to release a judgment check, you must submit a copy of the Judgement or Court Order to the Executive Assistant of the Corporation Counsel.

When a settlement check or judgment check is mailed, it must be sent certified mail. When a settlement check or judgment check is picked-up, the recipient of the check must sign a copy of the check. Proper identification must be presented matching the name and description of the recipient.

3. **Petty Cash Procedure**

The Office of Corporation Counsel maintains Petty Cash to cover miscellaneous needs: copying cots at legal libraries (funds are used to buy/increase value of copy cards), purchase stamps for the self addressed stamped envelopes (SASE) court mailings, costs of photograph development for case presentation, etc. All requests for

petty cash reimbursements must be made by completing a Petty Cash Reimbursement Request Form with the appropriate receipts stapled to the form. All completed requests must be submitted to the Executive Assistant to the Corporation Counsel for payment.

All funds disbursed from petty cash must be accounted for with receipts. Should a receipt not be available, you must indicate the reason on the memorandum. Reimbursements are made within one to two days. Periodically, the amount of cash is checked to assure balance with accumulated receipts. When cash becomes low, all memoranda are entered onto Munis. A check is issued payable to the Corporation Counsel and marked, "Hold for Corporation Counsel". The Corporation Counsel must then cash the check. Upon receipt of the cash, it is placed in the office safe located in the Executive Assistant to the Corporation Counsel's office.

4. **General Reimbursement Requests**

General reimbursement requests are for expenditures in excess of $10.00 for items that our office does not regularly purchase as office supplies. Any request for reimbursement of funds exceeding $25.00 must be pre-approved by the Corporation Counsel or Executive Assistant to the Corporation Counsel prior to making the purchase. This is to ensure that sufficient funds are available in the budget. Any person making unauthorized purchases is subject to a denial of reimbursement, even if otherwise reimbursable.

All requests for general reimbursements must be made by completing a General Reimbursement Request Form with the appropriate receipts stapled to the form. All completed requests must be submitted to the Executive Assistant to the Corporation Counsel for payment. A check is issued within two to four weeks.

5. **Mileage/Parking Reimbursement Requests**

The City reimburses its employees for mileage incurred while traveling on service for the City when a City vehicle is not available for such travel.

Upon pre-approval and completion of your trip, a Mileage Reimbursement Form must be completed and signed by the Corporation Counsel or Deputy Corporation Counsel. For parking reimbursements, receipts must be stapled to the mileage reimbursement form and submitted tot he Executive Assistant to

the Corporation Counsel for payment. A check will be issued within two to four weeks.

6. **Invoices/Bills**

Any and all bills, requests for reimbursements or invoices for payment of depositions transcripts, court reporter fees, witness fees, independent medical exam fees, sheriff fees, etc., must be signed by the attorney or staff member assigned to the matter, and must include the case name and office number, when applicable. The attorney or staff member shall then have his or her secretary enter the information on Citylaw and forward the original to the Executive Assistant to Corporation Counsel for payment. Vendor checks are mailed directly from Accounts Payable office unless requested otherwise.

7. **Supplies**

Due to the limited Petty Cash amounts allotted by the Controller's Office, items cannot be purchased arbitrarily, however urgent they may be, without pre-approval of the Corporation Counsel or Deputy Corporation Counsel.

A. Contract Processing

Effective February 23, 2001, the Controller's Office and the Corporation Counsel revised the Request for Agreement form and developed new Contract Processing Instructions. Refer to the attached Exhibits.

B. Short Calendar Procedures

Effective April 2, 2001, the Chief Administrative Judge of the Civil Division of the Judicial Branch for the State of Connecticut issued a standing order changing the method of transmittal of Civil Short calendar markings in Connecticut. Refer to the attached Exhibit.

C. Coregis Reporting Requirements

D. Property Damage Claims

All claims filed against the City of New Haven for property damage are handled by the Public Liability Investigators and an assigned Assistant Corporation Counsel.

E. False Alarm Claims

All claims against New Haven property owners for false alarms are handled through the New Haven Police Department and this Office. A paralegal and an Assistant Corporation Counsel is assigned the task of collecting the fines and/or instituting claims against property owners in New Haven Small Claims Court.

F. Freedom of Information Requests

All Freedom of Information Requests are monitored by a paralegal and an assigned Assistant Corporation Counsel.

G. Litigation Settlement Committee

The Litigation Settlement Committee meets every other week in the Office of the Corporation Counsel to review, discuss, and vote on all proposed settlements of lawsuits or claims against the City of New Haven in excess of $5,000.00. This Office also informs this committee of all judgments as a courtesy.

Several forms must be completed prior to each Litigation Settlement Committee meeting:

1. Recommendation to Compromise

A standardized form is prepared by the attorney or, in the case of a claim that is not in suit, by the investigator, assigned to the matter and reviewed by the Corporation Counsel prior to the committee meeting. Once approved by the committee, this form is forwarded to the Mayor for approval and signature.

The attorney or staff member assigned to the matter shall have his or her secretary enter the settlement or judgment information on Citylaw and forward the original to Accounting for payment. All settlement checks and judgment checks are marked, "Hold for Corporation Counsel" and must be picked-up from Accounts Payable.

2. Notice of Meeting and Agenda

The Agenda is published in the form of a memorandum and addressed to all committee members, indicating that the meeting will occur, date, time and place. Meeting schedules are developed at the beginning of the calendar year, and provided to all committee members. Currently, meetings are scheduled every other week on Wednesday, at 5:30 p.m. in the Corporation Counsel large conference room. Meetings occur and agendas are sent out only when there is business to come before the committee. When there is business, an agenda is provided, using office case numbers only. The agenda items are pre-approved by the Corporation Counsel. This notice should be prepared on the Friday before the meeting, and delivered to the committee members, with the written recommendations, on that Friday. At the same time, a letter is prepared and delivered to the City-Town Clerk, summarizing the agenda information. This letter is provided to the clerk to post in compliance with the State "Sunshine" law. Items may be added to the agenda, provided a revised letter is forwarded to the city-Town Clerk for posting no later than 24 hours prior to the scheduled

meeting. Names and addresses of current committee members can be obtained through the Office of Legislative Services or through the Mayor's Office

On the Tuesday before a scheduled meeting, a staff member must telephone all committee members to request confirmation of their attendance at the proposed meeting. Results of these calls are reported to the Corporation Counsel for his or her decision regarding quorum. There must be 4 members to assemble a quorum.

3. **Minutes**

A staff member will attend the meetings and take minutes of the non-executive portion of the meetings. Minutes should be modeled in proper format. Minutes are placed on the agenda of the next committee meeting for review and approval. Upon approval, they are kept by a staff member also with copies of the signed approved recommendations to compromise forms that were approved in that meeting.

H. Board of Aldermen Submissions

Effective July 2, 2001, the New Haven Board of Aldermen adopted "Rules of the Board of Aldermen". In addition, in January 2001, Aldermen Philip Voight, Finance Committee Chair issued a memorandum concerning the required documents and information for aldermanic submissions. Refer to the attached exhibits.

I. Boards and Commissions

Connecticut statues contain procedural requirements for board meeting notices, voting and record keeping. Refer to the attached exhibit depicting those guidelines.

J. File Disposition Procedures

Any matter can be closed-out in any one of the following ways:

1. Negotiated settlement
2. Court ordered award
3. Failure to file action in period permitted by law
4. Withdrawal by party

The attorney assigned to the matter must ensure that all disposition documents are placed in the file before proceeding to initiate closeout procedures and/or make a payment to the plaintiff. A Case Disposition form must be completed for every closed matter.

The following are standardized forms to be used where applicable:

1. **Recommendation to Compromise**

   This form is used for all settlements. This form is prepared by the attorney or paralegal handling the matter and is given to the Corporation Counsel and to the Mayor for review and signature. Settlements in excess of $5,000.00 must be approved by the Litigation Settlement Committee before Corporation Counsel and the Mayor can sign off on this form. When this form is returned signed, the attorney should seek release and withdrawal forms from the plaintiff/plaintiff's counsel.

2. **Release and Withdrawal**

   Standardized release and withdrawal forms must be filed in the court upon payment to the plaintiff.

3. **Request for Payment**

   A Request for Payment must be forwarded to Accounts Payable along with a copy of the Recommendation to Compromise. It is in the form of a memorandum. Your assigned secretary shall draft it. The original settlement form, release and withdrawal or court order must be attached to the payment request memorandum.

   The Accounts Payable office provides us with the check, rather than mailing such checks. This can result in delays unless care is taken. If at all possible, the release and withdrawal, stipulation of dismissal, satisfaction of judgment, should be obtained as soon as the submission of the request for payment, and the attorney can advise the plaintiff/plaintiff's attorney that the City will file only upon notification from the plaintiff's counsel that the check has been received. The withdrawal, stipulation or satisfaction will then be filed with the court. If the plaintiff/plaintiff's counsel refuses, the request must reflect "Hold For Corporation Counsel". The check will then be received in the Office of the Corporation Counsel, and the attorney will be notified. It s the attorney's responsibility to contact plaintiff/plaintiff's counsel, arrange exchange or check for the withdrawal, and file the appropriate documents in court.

4. **Case Disposition Form**

A standardized Case Disposition Form must be completed and must be provided to the case management data entry person. A copy is also placed in the file for storage.

K. File Management

1. **Litigation and Department Files**

Each attorney must maintain current open litigation and department files in their offices or in the file cabinet space in the office's center area.

2. **Contract Files**

Contracts are placed in a manila folder and marked with the office assignment number and are stored in the file cabinet spaces in the office's center area. All contract files are archived at Jefferson Archives after four years provided that the contract has expired.

At the time of execution, the backup file previously maintained by the assigned attorney is merged with the executed contract in one file. The "backup file" may contain the RFA form and attached documentation, any correspondence concerning negotiation or drafting of the contract, and any other document necessary to explain or justify one or more provisions of the contract.

3. **Office-Wide Department Files**

4. **Office-Wide Subject Files**

The Corporation Counsel and the Executive Assistant to the Corporation Counsel maintains subject files located in file cabinets in the office's center area.

5. **Shredding Policy**

It is important to comply with all State and Federal Record and Retention laws when deciding to destroy legal materials.

As stated in Section F(8) above, all materials waiting to be shredded must be deposited in the container located next to the shredder in the copy room. For those materials that do not fit in the container, they must be deposited in a box, clearly marked with the instructions and placed next to the container.

6. **Archiving Closed Litigation Files**

Due to a lack of storage space in the office, all litigation matters that are closed beyond 1.5 years are boxed and forwarded to Jefferson Archives approximately twice a year.

7. **Letterbooks**

Each attorney should keep a chronological "letterbook". After one year, the letterbook documents should be destroyed.

L. Investigation Requests

M. Interns

All student interns must be cleared through the Department of Human Resources. This includes student who are both paid and volunteers/academic. For paid interns, a Record of Hours Worked form must be completed every week and submitted to the Executive Assistant to the Corporation Counsel for payroll purposes. Refer to the Exhibit for additional information.

1. **Law Student/Paralegal Interns**

Law students and paralegal student interns report directly to an assigned attorney or other designated person. All requests and assignments must be directed in writing. See copy of the Request for Research for Law Student/Paralegal form.

2. **Non-Law Student Interns**

Non-laws student interns report directly to the Executive Assistant to the Corporation Counsel or other designated person.

N. Court Filing Procedures

1. **Local Filing**

Court filing generally takes place between the hours of 3:00 and 4:00 p.m. each day by the Legal Assistant/Paralegals or the Student Interns. For New Haven Superior Court, the original documents along with copies must be dropped off in the basket located on the counter in the Clerk's Office. The stamped copies are made available for pick-up the following day.

2. **Long Distance Filing**

The schedule for long distance filing in Hartford and in Bridgeport is constantly changing. All matters for filing outside of the New Haven area should be ready no later than 2:00 p.m. Notification must be given to the Legal Assistant/Paralegal on the schedule as soon as possible.

Long distance filing by the Legal Assistant/Paralegal should be the exception and not the rule. If there is an alternative method of filing that does not jeopardize the case, please consider it. Emergencies should be cleared through Corporation Counsel or a Deputy Corporation Counsel.

O. Library

1. Westlaw

This Office subscribes to Westlaw through WestGroup. Access is available through the website www.westlaw.com. Each attorney and paralegal is assigned a password for use when logging onto Westlaw. At no times should you share your Westlaw password with anyone unless pre-approved by the Corporation Counsel or a Deputy Corporation Counsel.

There are areas in Westlaw that are not available to our office. If you attempt to enter an area not included in our service a warning window will greet you. You must not go beyond that warning window without approval from Corporation Counsel. Once you do so, the office will be billed additional charges.

2. Office Law Library

Access to Westlaw and the Office Law Library are luxuries, not entitlements. Please respect your colleagues by keeping the law library neat and reshelf your own books.

3. Yale New Haven Law Library

Each attorney and paralegal shall receive a library card to gain access to the Yale New Haven Law Library located on Wall Street.

4. New Haven Superior Court Bar Library

A copy card for the New Haven Superior Court Bar Library is available from the Executive Assistant to the Corporation. If you use your personal funds for making copies, a "petty cash reimbursement" form must be completed and submitted to the Executive Assistant to the Corporation for payment.

OFFICE OF THE CORPORATION COUNSEL

MEMORANDUM

TO: Office Members

FROM: Victor A. Bolden, Corporation Counsel VB

DATE: February 1, 2011

RE: **Legal Opinions**

Effective immediately, to ensure uniformity in the issuing of opinions by this Office, the following guidelines have been established:

1. Every legal opinion should use the "Office of the Corporation Counsel Opinion" format as a document.

2. Every legal opinion should contain four sections: (1) an "Issue" or "Issues" section; (2) a "Short Answer" section; (3) a "Relevant Legal Provisions" section and (4) a "Discussion" section.

3. Any legal provisions identified in the "Relevant Legal Provisions" section should be detailed in the "Discussion" section of the Opinion or attached as an Appendix to the Opinion.

4. Every legal opinion should end with the same sentence set apart from any other text: "This opinion is limited to the issue set forth and does not apply to any other situation not discussed herein."

5. All legal opinions issued by this Office must be co-signed by me, scanned and saved onto Citylaw. This effort will make it easier for everyone to locate all legal opinions prepared by this Office. Please continue to submit your legal opinions to Nancy Pepe, so that she may assist with either the scanning and/or placement into the Legal Opinion Book located in the library.

Thank you for your cooperation in this matter.

Sec. 2-162. - Legal services contracts.

No city official, employee or agency (except the board of education for contracts not exceeding one (1) year) shall engage any individual or firm to provide legal services to or on behalf of the city, nor shall any city funds be spent or obligated for such purpose, without prior aldermanic approval. The corporation counsel shall submit requests for such approval (other than those originating with the board of aldermen) to the president of said board on behalf of the originating agency, official or employee. All requests for such approval shall be accompanied by a draft of the contract to which the request pertains. Approval by said board shall be required unless approved by at least two (2) members of aldermanic leadership, which for these purposes shall be its president, majority leader and minority leader. A copy of each legal services contract executed on behalf of the city shall be filed promptly with the controller, city clerk and corporation counsel.

§ 2-162 amends and supersedes former § 2-182 which derived from the Ord. of 7-6-93; Ord. of 3-15-99.

Sec. 2-376. - Authorization of contracts to be executed one year from date, and non-bid contracts in excess of one hundred thousand dollars.

(a) Unless expressly authorized by law or by vote of the board of aldermen, the city shall not be bound by any contract executed after one (1) year from the date thereof. The board of aldermen's prior approval is necessary for any city contract that does not go to bid that costs more than one hundred thousand dollars ($100,000.00).

(b) The determination of whether a contract is to be executed after one (1) year shall include its initial term plus all automatic renewals and options to renew. Any renewal which materially alters the terms or conditions of a contract shall be resubmitted to the board of aldermen for approval.

§ 2-376 amends and supersedes former § 2-40 which derived from the Code of 1928, § 462; Ord. of 9-4-90, §§ 1, 2; Ord. of 3-12-01; Ord. of 4-2-01.

Sec. 60. - Transfers during fiscal year.

The board of aldermen may establish by ordinance from time to time an amount of appropriation under the approved budget which the controller with the approval of the mayor shall be authorized to transfer between line items within any department or from one department to another. No such transfer in excess of such authorized amount shall be implemented unless it shall be proposed by the mayor and approved by the board of aldermen, provided that an increase in the total appropriation shall be approved only by vote of two-thirds of the entire board of aldermen. Each approved transfer shall be described in the monthly financial report prepared by the mayor pursuant to section 62.

REQUEST FOR AGREEMENT (RFA) AUTOMATED PROCESSING

Using Adobe LiveCycle & City Law

As of July 2009

1. Enter Adobe LiveCycle with the following:
   User: ppopoliz/Password: xxxxxxx

2. Select the word Worklist

3. Select +

4. Select Counsel Approval

5. Select Checkmark

6. Highlight Purpose from Section 4 of RFA, Right Click & Copy Contents

7. Review Contractor Name & Amount Information (you may wish to write this information on separate note pad)

8. Enter Citylaw & Open Assignment Module

9. Enter Contractor Name & Amount Information in Citylaw (with other information)

10. Paste the Purpose from the RFA in the Description Section in Citylaw (Ctrl-V)

11. Write the Citylaw # & Assigned Attorney on separate note pad

12. Go back to RFA, Section 22A and locate Pamela Popolizio under Counsel Assigned Section & Enter Citylaw # in Contract # Section

13. Select Submit Request on RFA (Do Not fill-in Section 22B at this point!)

14. Select the word Worklist

15. Select RFA

16. Select & change Section 22A from Pamela Popolizio to the actual Attorney Assigned to the RFA

17. At Section 22B, Select the Checkmark and Sign (Pamela Popolizio's name should appear—use her password xxxxxx)

18. Select Save (ikon located at top left of RFA document) RFA in My Documents

19. Name RFA as: RFA.A09.XXXX

20. Select Submit Request on RFA

21. Go back to Citylaw, Section Other Files, Import RFA

22. Select Email Log in Citylaw & Hit New to Send the Assigned Attorney a quick note that a new RFA has been assigned to them (Do Not attach the actual RFA to the email because it is already saved in Citylaw!)

IKON Enterprise Services

Request for Agreement Automation Project

User Reference Guide LiveCycle ES2

The City of New Haven

Document Efficiency

Effective 6/7/10

User Reference Guide

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PREFACE

The Request for Agreement (RFA) Automation Project is an effort by The City of New Haven Bureau of Purchases to improve an existing paper-based business process through implementation of a rules-based workflow and intelligent document (eForm).

Rather than assembling paper documents and completing the RFA form with ink, the Originator will complete a dynamic and interactive portable document form and upload attachments to it. This is beneficial as most of the attachments are within the city's control and are "born digital". Inherent in the new electronic form will be structure, validation and rules that will not allow the originator to advance through the process without the necessary conditions being met. For those supporting documents that are not received in a digital format, they will need to be scanned using one of the city's existing scan-enabled multi-function devices.

What's In This Guide?

The User Reference Guide provides basic instruction to the participants in the workflow regarding how to access the software system, the business rules of the form and what to expect when interacting with the workflow.

How Is This Guide Organized?

The Guide is organized chronologically from the perspective of the original submitter (Originator).

A first time user or person unfamiliar with the RFA process would be able to follow along step-by-step, i.e. page-by-page, and complete a Request for Agreement.

Tips for usage are called to the reader's attention with a icon.

Applicable business rules are called to the reader's attention with a icon.

Text appearing in brackets, e.g. [Submit], indicates it is a button to be clicked by the user.

Text appearing in *italics* indicates a name that appears within the Form Server or the eForm itself, e.g. Go to *My Worklist* to open the form.

Who Should Read This Guide?

This Guide is intended for all participants in the workflow. This includes the:

Originator – Any individual who prepares a form, attaches supporting documents and kicks-off the workflow but submitting the RFA for approval.

Approver – Any individual with proper authority to sign-off for a given department or role.

Completer – Any individual involved with the actual creation and execution of the Agreement. This individual also has the final approval.

Who Do I Contact If I Have Questions?

For questions regarding the business process or how to fill out the intelligent form contact the Bureau of Purchases.

Michael Fumiatti
203-946-8201
mfumiatt@newhavenct.net

For questions with your PC, Internet Explorer, Form Manager, Acrobat or technical issues in general contact IT Support.

THE WORKFLOW SYSTEM

The Adobe® LiveCycle® ES2 family of enterprise software enables organizations to create, deploy, and optimize solutions to more efficiently capture, process, and archive information. It combines robust process management with electronic forms, document security, and document generation in an integrated and cohesive set of products.

At use in the RFA Automation Project are the following components:

- Workflow
- Workspace
- Forms

A typical participant will interact only with the intelligent form and the Workspace. The Workflow will operate unattended in the background.

Accessing the System

Access to the system is had via the standard Internet Explorer Browser.

Steps to Login

To login to the Workspace perform the following steps.

Step 1. Enter the URL "http://172.18.81.140:8080/workspace" (without quotes) in the address bar of your browser.

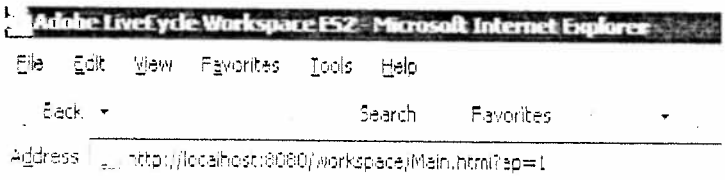


Figure 1 - Browser URL

The Adobe LiveCycle Workspace ES2 will display as shown in Figure 2 below.

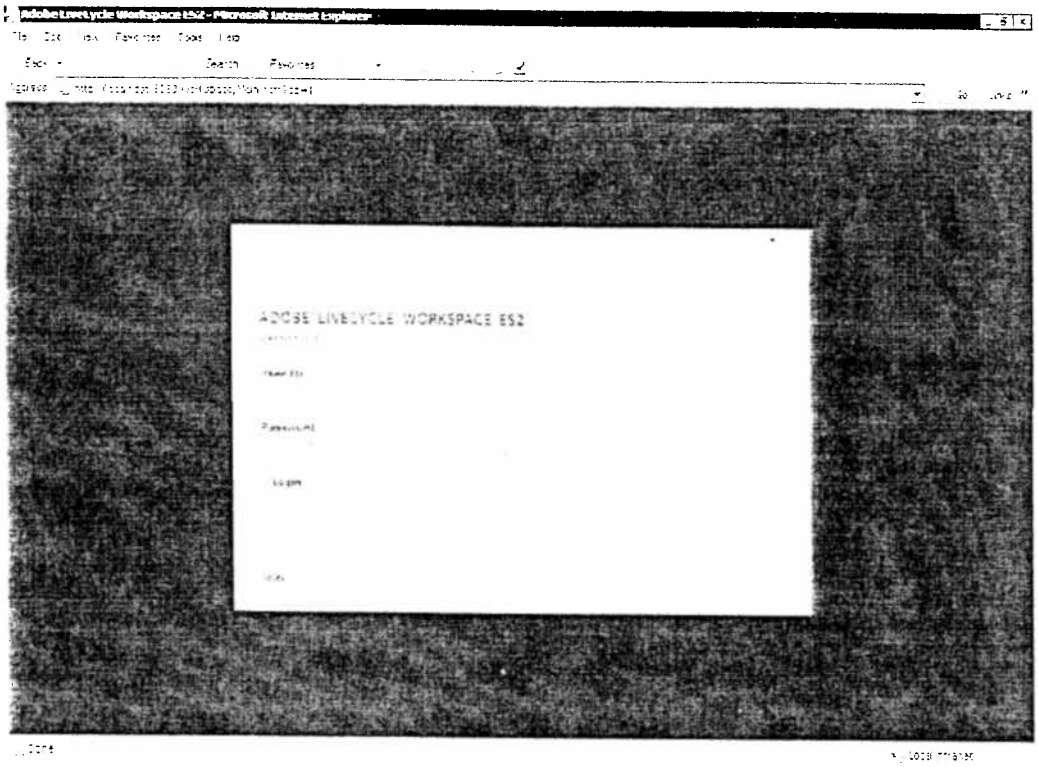


Figure 2 - Workspace Login Screen

Step 2. Enter your City of New Haven username and password.

Step 3. Click [Login].

TIP – Save the URL as a Favorite in your browser. When you're looking at the Workspace Login (above), choose *Favorites* from the Menu and select *Add to Favorites*.... Then just give it a name and click [Add]. From now on you can access the site by selecting it from your browser Favorites list.

Steps to Trigger the Workflow:

To begin a new RFA perform the following steps.

Step 1. Select the *Start Process* icon in Workspace.

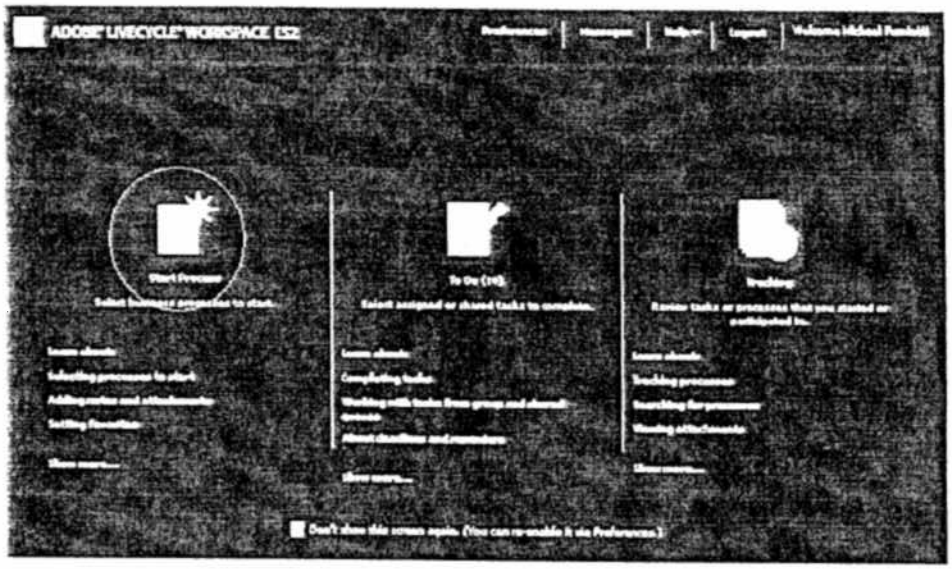


Figure 3 - Forms Selection

Step 2. Select the *RFA* category as shown in Figure 4 below.

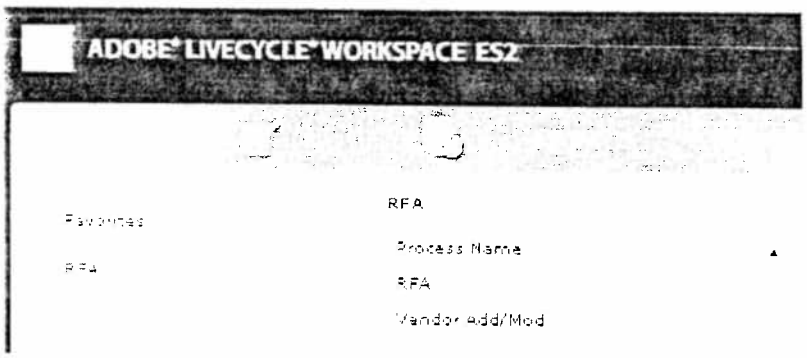


Figure 4 - Initiate RFA Form

Step 3. Initiate a new form by clicking the process name as shown in Figure 4 above.

Step 4. Click [Complete] to trigger the work flow. An empty RFA form will be placed in your work list (labeled *<your username>* under *To Do*.)

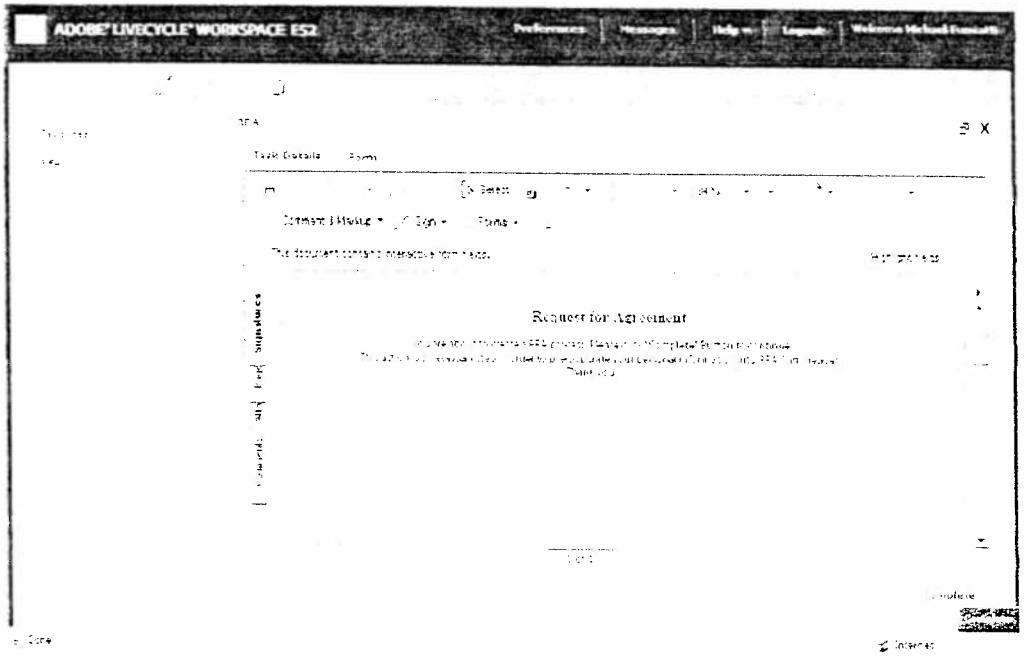


Figure 5 - Submit a New RFA Form

You can only initiate one form at a time. After clicking the [Complete] button a warning dialogue will display directing you to the *<your username>* queue to process the RFA.

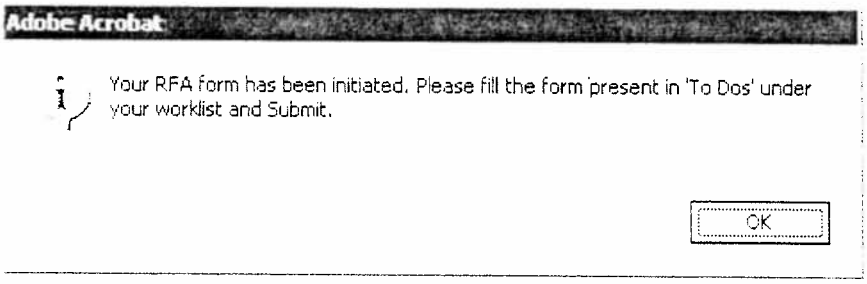


Figure 6 - Initiation Warning

Working with Forms

Now that you have initiated a new form you can begin the steps necessary to complete and submit it to the workflow for processing.

Steps to Complete the Form:

To begin working with a new form perform the following steps.

Step 1. Go to your worklist and open the form.

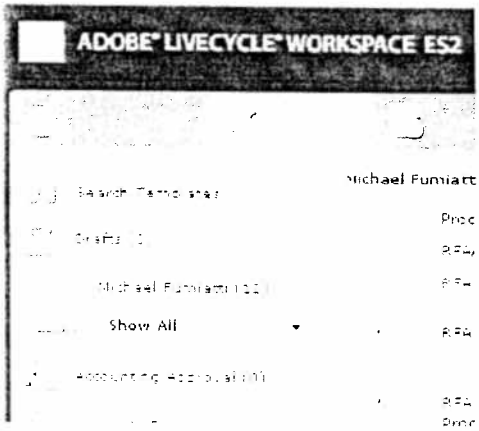


Figure 7 - My Worklist

The contents of your work list will be displayed as shown in Figure 8 below.

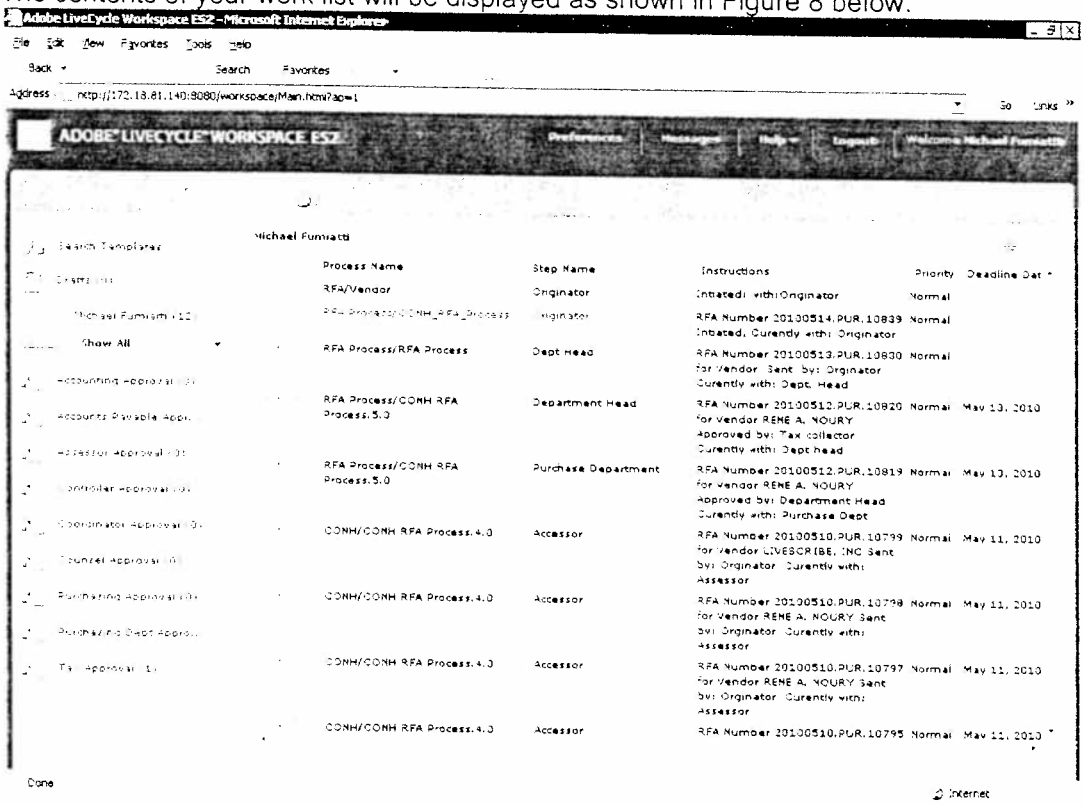


Figure 8 - My Worklist (Queue Contents)

TIP – The contents of the work list can be sorted in different ways depending on your preferences. Also, make note of the Task Id number in the left-most column. This will help you sort out this RFA from others in the list.

Step 2. Open a form by double-clicking the Process Name.

Refer to Request for Agreement Form beginning on page 13 for more information on completing the form.

Viewing Form Attachments

As the RFA progresses through the preparation process various attachments will be uploaded, e.g. Scope of Services, Disclosure & Certification Affidavit, etc.

Steps to View the Attached Documents:

To view attachments to the RFA perform the following steps.

Step 1. Select the *Attachments* tab in the lower left of the form window.

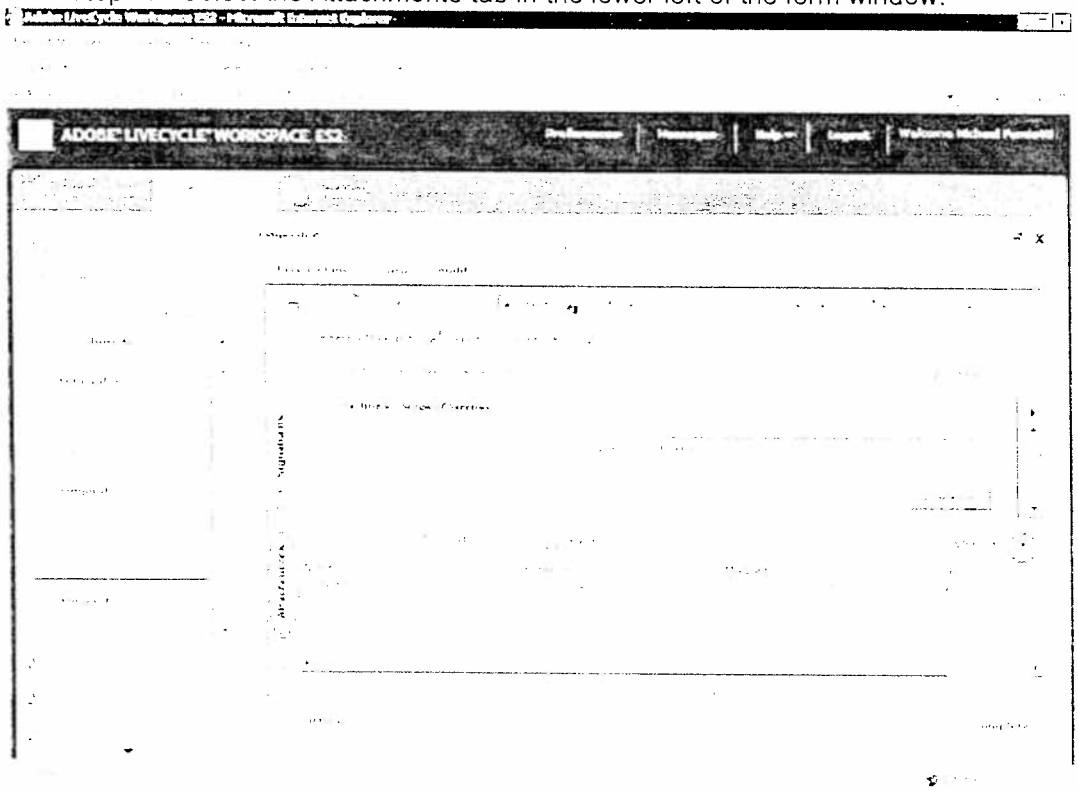


Figure 9 – Viewing Form Attachments

Step 2. Double-click an item in the list to view it.

To close the Attachments list click the [X] on the right-hand side of the panel.

Monitoring the Form

Visibility into the RFA process is provided in two ways. First, the originator is notified at each step as the form advances. Second, the entire history of a form can be seen if you are a participant.

Event Notifications

The system has been configured to provide notifications as a form advances through the workflow, as an event is reaching an escalation point and when a form has been completed.

From: nhadmin@newhavenct.net **To:** MFumiatt@newhavenct.net **Cc:** rfaquote@newhavenct.net; mfumiatt@newhavenct.net
Subject: RFA# 20081008.PUR.10077 for TIGHE & BOND, INC- Approved and sent to Accounting.

Michael Fumiatti,

RFA Number 20081008.PUR.10077 for TIGHE & BOND, INC has been sent to Accounting.

This mail is for notification purposes only. Do not reply.

Figure 10 - Email Notification on Status Change

The system has also been configured to send a notification if a work item is not addressed in a timely manner.

Audit Trail

The history of a form appears as a form list. Each item in the list represents a view of the form at each stage in the process. When you open a form from the list, it appears as it did at the associated stage in the workflow. You can open the form only for the stages in the business process where the form was placed in a work list to which you have access.

At any time the Work History of an RFA form can be seen by any participant in the RFA workflow. To see the history of an RFA perform the steps below.

Step 1. Access the *Tracking* tab

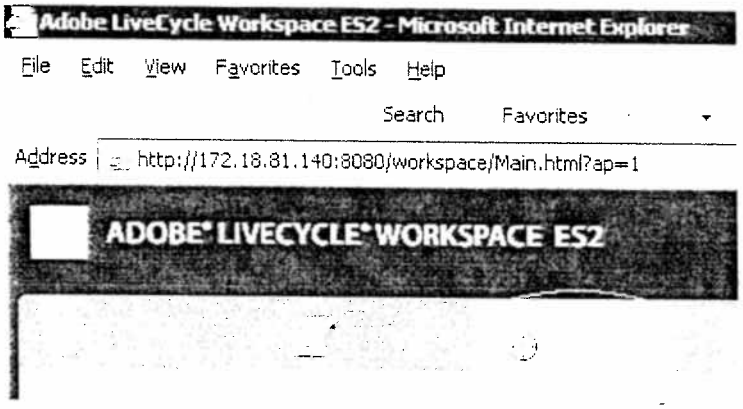


Figure 11 - Accessing the Work History

Step 2. Identify the correct RFA (by Task Id/Instance Id) and click on it.

Type	Instance ID
	2025

Figure 12 - Work History Icon

Step 3. Review the work history chronologically from the bottom up.

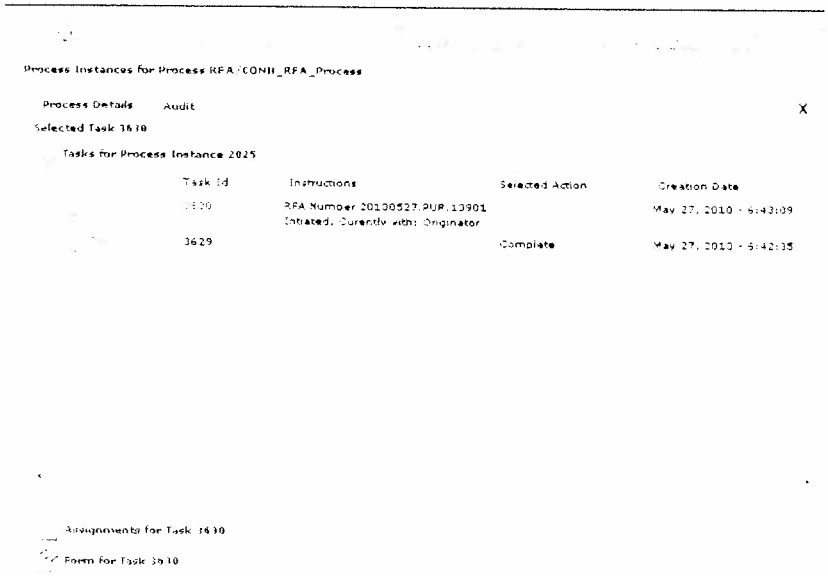


Figure 13 - Work History

REQUEST FOR AGREEMENT WORKFLOW

Due to statutory requirements for allocation of city funds, the future RFA process tolerates little change to the approval process but allows for great improvement overall by implementing an electronic form and automated workflow.

Upon completing the form, the Originator submits the form to the workflow server. Based on conditions in the form and the workflow rules, the workflow server will determine to whom the form is routed for approval. Forms will follow a process very similar to what is seen in Figure 14 below.

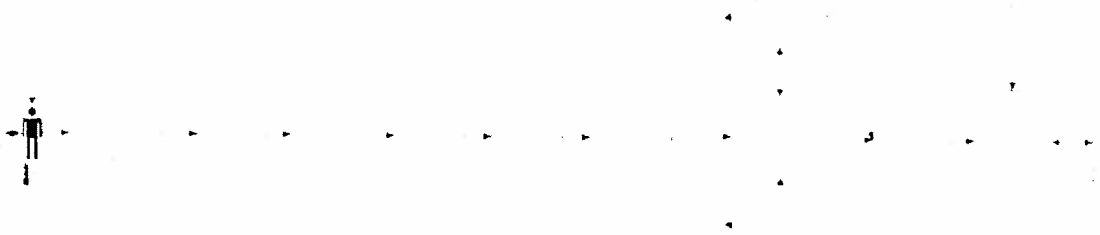


Figure 14 - RFA Workflow Map

For each advancement step of the RFA through the Approval Process, a simple notification will be sent back to the Originator. For example, once the form is approved in Purchasing a notification email is sent to the Originator letting him/her know the RFA has left Purchasing.

REQUEST FOR AGREEMENT FORM

The RFA form is an intelligent portable document (PDF) that will captures all the information required by the RFA process. The form has data validation, calculation, lookup to MUNIS and other intelligent facilities.

The Originator's information will pre-populate in the form based on the login of user. Otherwise, the initial form will be blank.

In addition to validations, calculations and lookups, elements at use in the form to provide structure include drop-down lists and radio buttons.

Figure 15 - Drop-down List

Click the triangle to the right of the drop-down box to show the list. Some lists allow multiple values to be selected whereas others do not.

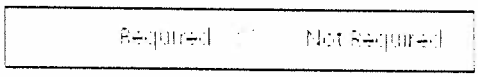


Figure 16 - Selection (Radio) Buttons

Radio buttons allow only one value to be selected. Based on the selection the form dynamically presents other elements.

Completing the Form

The Originator of the RFA is asked to provide information about the terms of the agreement and the vendor. That information is collected and stored as part of the RFA form itself.

Section 1 – Date and Department Information

The RFA Number will number and Request Date will be provided automatically by the form. These fields cannot be changed.

The RFA Priority and Department can be updated as needed.

Note – If you choose to indicate a priority of "High" a reason must be provided.

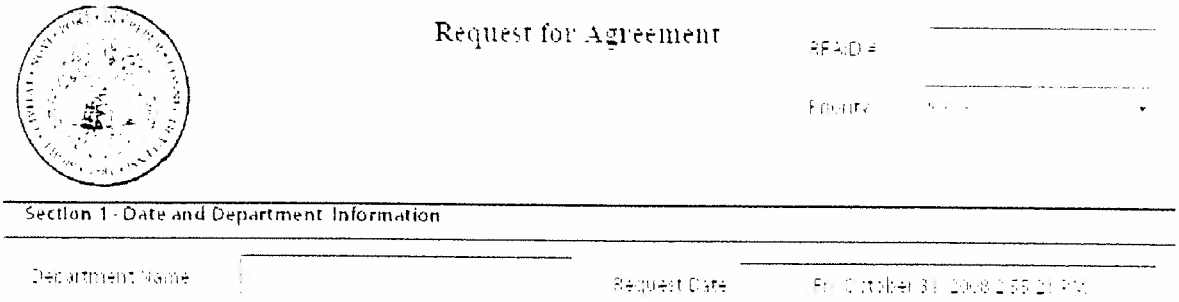


Figure 17 - RFA Form Header

TIP – If the Department Name that appears for your login is not correct it can be changed. The RFA Number, however, will stay in its original form.

Section 2 – City Contact Information

The originators name, email and phone number will be populated from the Form Manager login information. Only the phone information can be changed.

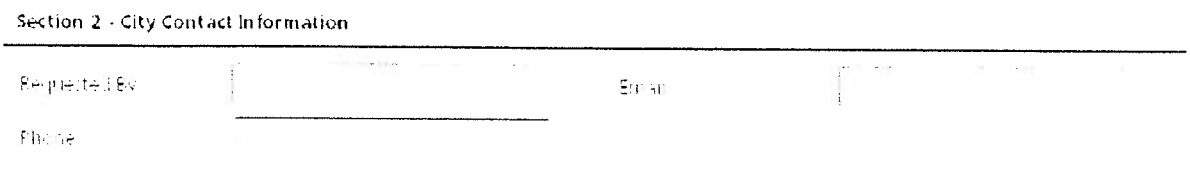


Figure 18 - Originator Information

TIP – If the Phone Number is missing or not correct it can be entered/changed.

Section 3 – Agreement Type

Select the type of agreement from the drop-down list.

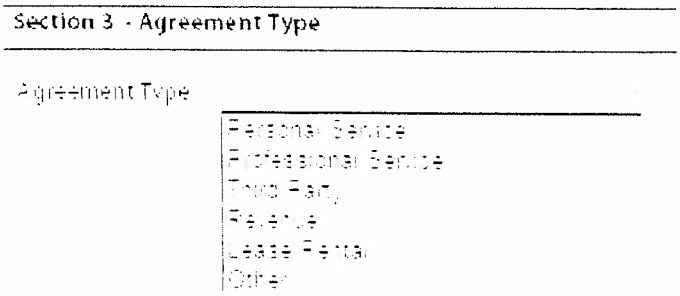


Figure 19 - Agreement Type Selection

If "Other" is selected an information dialog is displayed requesting additional information about the "other" agreement type.

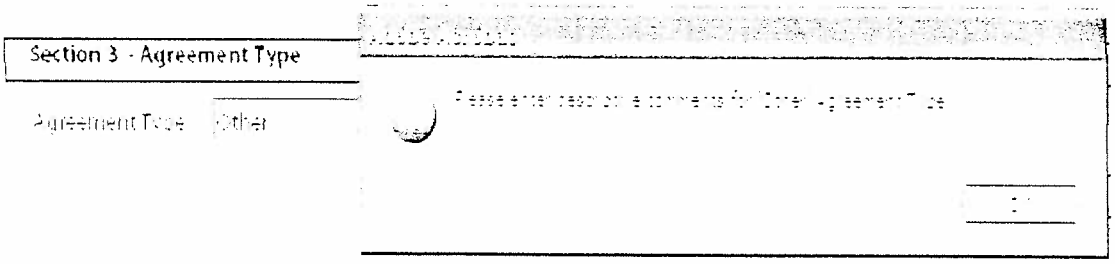


Figure 20 – Warning Dialogue for "Other"

Note – Any time "Other" is selected from any drop-down list in the form a descriptive comment is required.

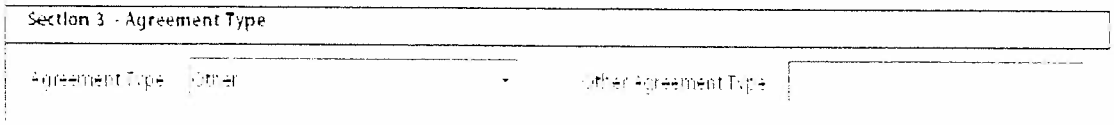


Figure 21 - Description of "Other" Entry

Section 4 – Purpose

Enter a brief description of the agreement being requested. You are allowed 100 characters only. Additional information can be provided later in the Scope of Services section.

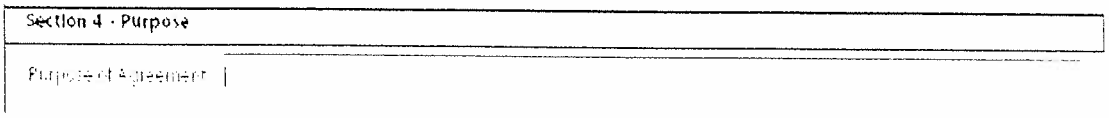


Figure 22 - Description of Purpose of Agreement

Section 5 – Type of Purchase

Select the Type of Purchase for the agreement. The remainder of Section 5 will adapt to your selection.

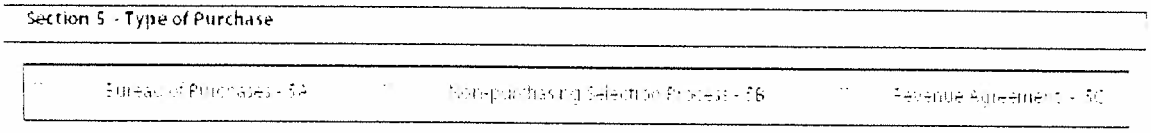


Figure 23 - Type of Purchase Options

Section 5a – Type of Purchase – Bureau of Purchases

For Type of Purchase - Bureau of Purchases select the first radio button.

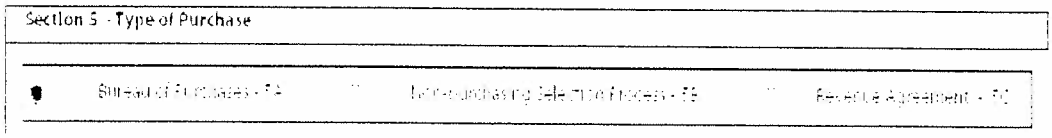


Figure 24 – Selection of Bureau of Purchases – 5A

The remainder of Section 5A will adapt to your selections.

For an RFP you will be asked to provide the number and attach any related documents.

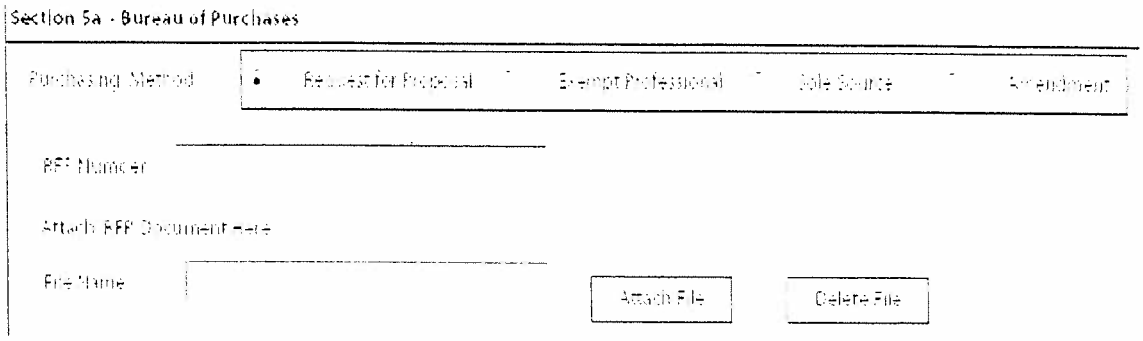


Figure 25 - Selection of Request for Proposal and Details Needed

For an Exempt Professional you will be asked to identify the type of professional.

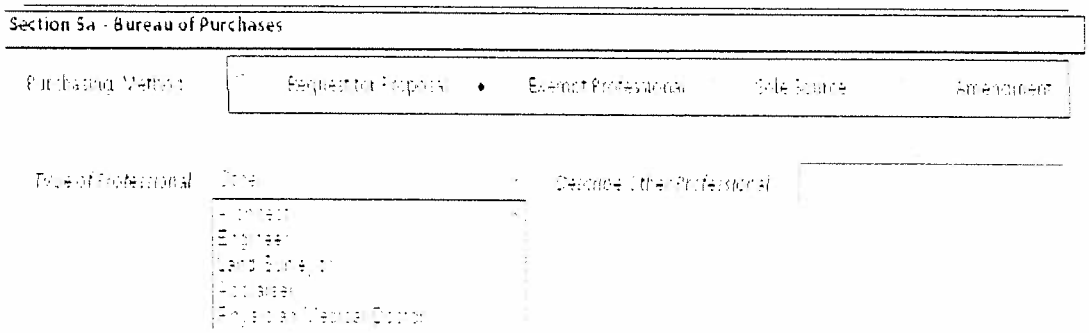


Figure 26 – Selection of Exempt Professional and Details Needed

For Sole Source you will be asked to attach the Purchasing Department's Sole Source Memo.

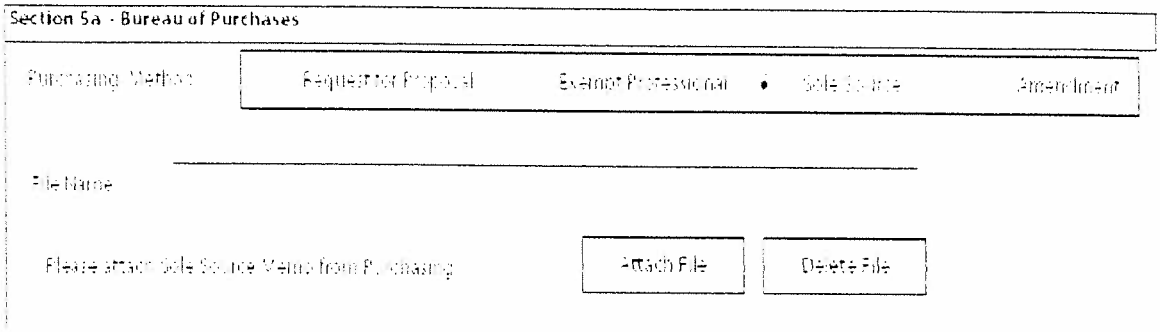


Figure 27 – Selection of Sole Source and Details Needed

For an Amendment you will be asked to provide several pieces of information including the number, amounts and dates. If Alderman Approval is necessary attach the documentation.

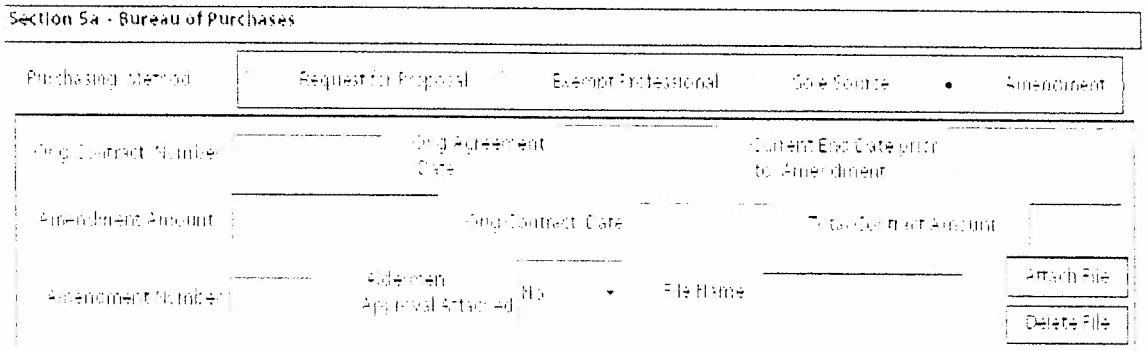


Figure 28 – Selection of Amendment and Details Needed

For non-RFP Purchase Methods, Board of Alderman approval is mandatory where the amendment amount or total contract amount exceeds $100,000USD. If this is the case, the originator will be required to upload the approval documentation.

TIP – Date fields can be manually typed, e.g. 9/30/2008, the date can be selected from a calendar.

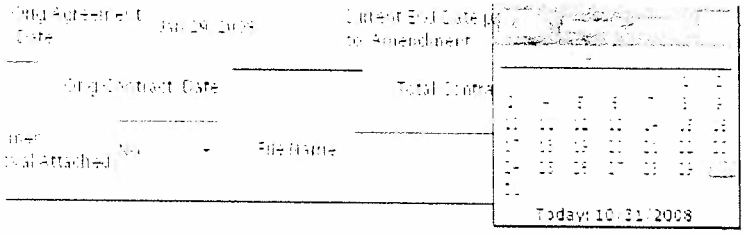


Figure 29 - TIP for Entering Dates

Section 5b – Type of Purchase – Non-purchasing Selection Process

For Type of Purchase – Non-purchasing Selection Process select the second radio button.

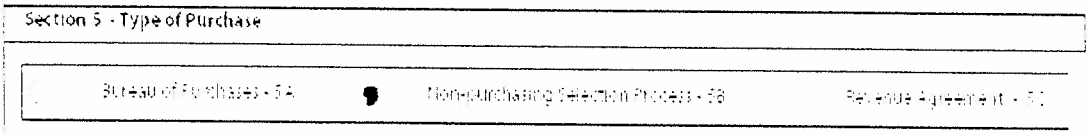


Figure 30 - Selection of Non-purchasing Selection Process – 5B

The remainder of Section 5B will adapt to your selection.

For a Community Development Block Grant attach the Board of Alderman approval documents.

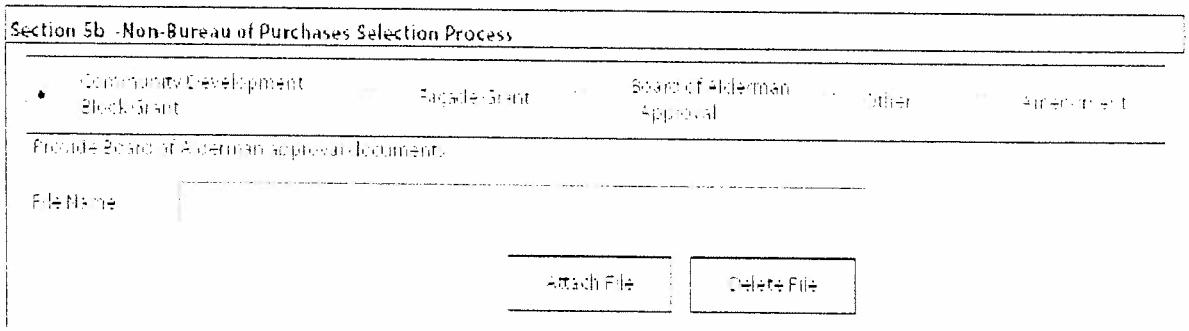


Figure 31 – Selection of CDBG and Details Needed

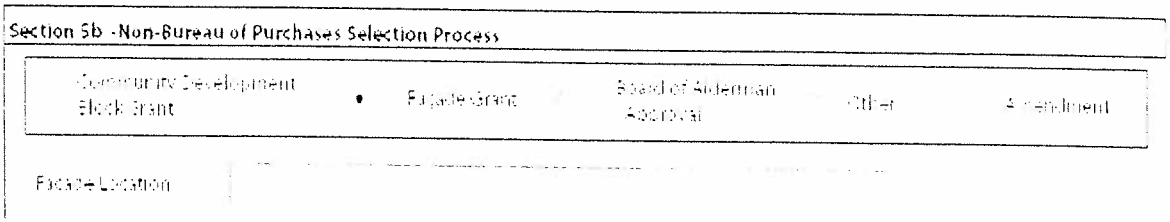


Figure 32 – Selection of Façade Grant and Details Needed

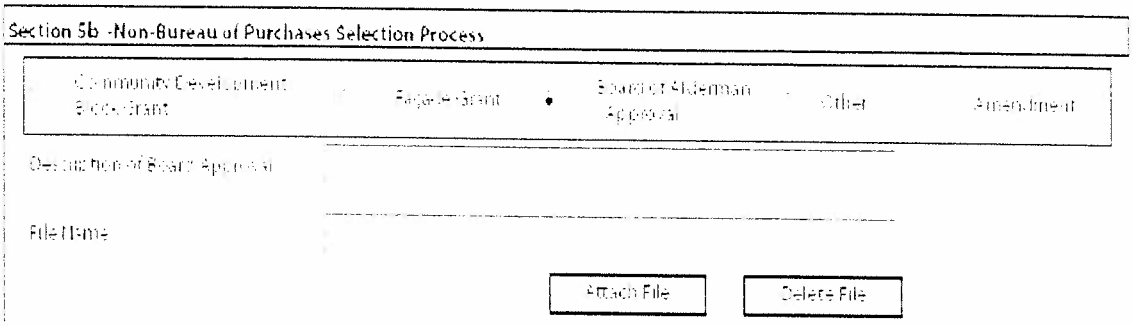


Figure 33 – Selection of Board or Alderman Approval and Details Needed

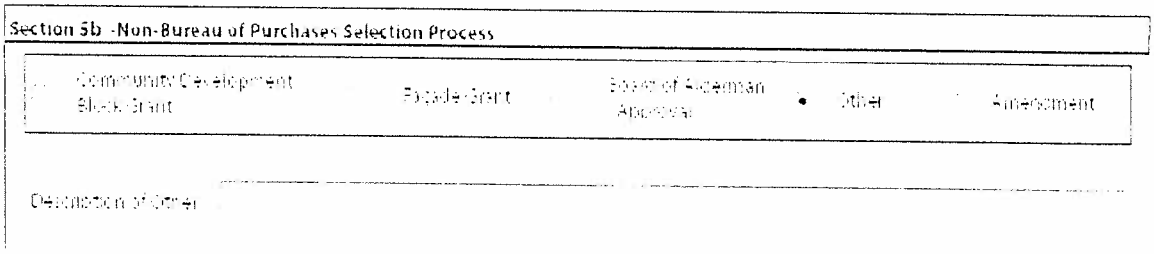


Figure 34 – Selection of Other and Details Needed

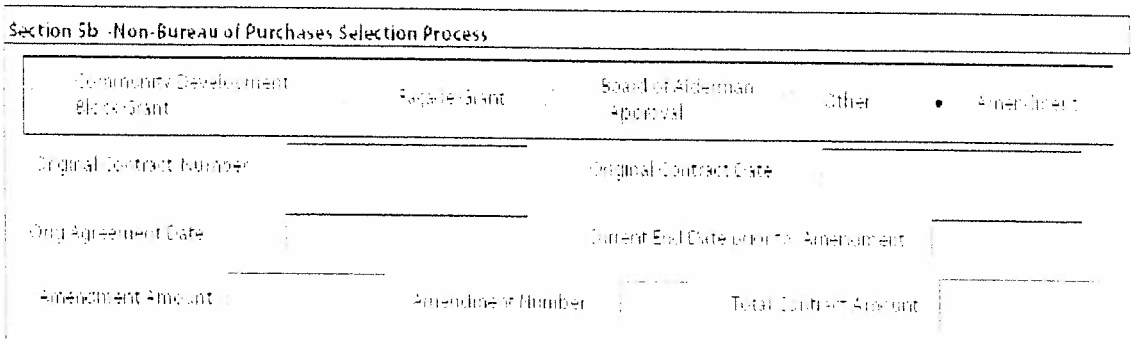


Figure 35 – Selection of Amendment and Details Needed

For non-RFP Purchase Methods, Board of Alderman approval is mandatory where the amendment amount or total contract amount exceeds $100,000USD. If this is the case, the originator will be required to upload the approval documentation.

Section 5c – Type of Purchase – Revenue Agreement

For Type of Purchase – Revenue Agreement select the third radio button

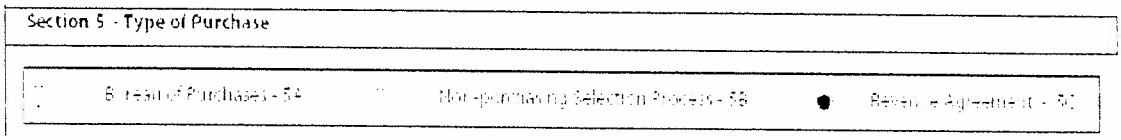


Figure 36 - Selection of Revenue Agreement – 5C

For all Revenue Agreements a valid MUNIS Revenue Account Number must be provided.

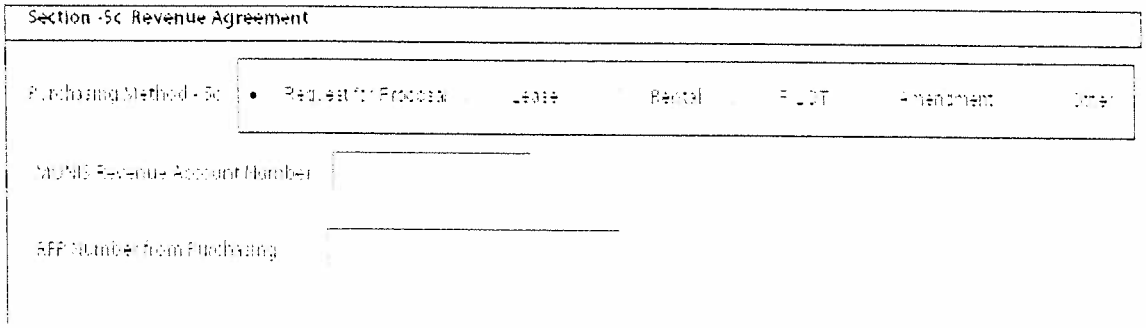


Figure 37 – Selection of RFP and Details Needed

For Lease, Rental and PILOT only the MUNIS Revenue Account Number must be provided.

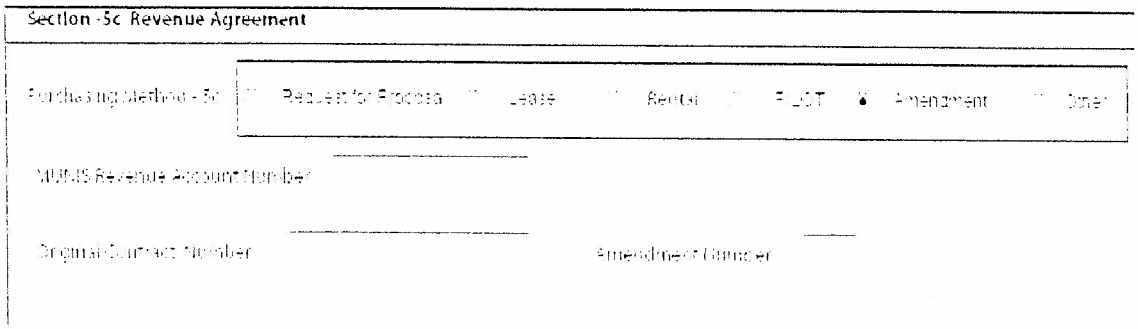


Figure 38 – Selection of Amendment and Details Needed

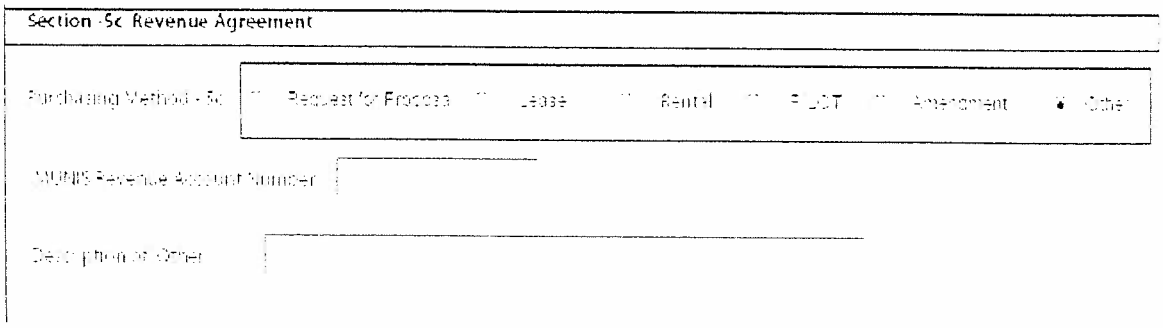


Figure 39 – Selection of Other and Details Needed

Section 6 – Scope of Services

A detailed description of the services to be provided, work products and time frames for completion and any other requirements should be attached to the RFA. The form and content should be as you wish it to be incorporated into the Agreement. This information is required by Corporation Counsel to draft the Agreement and it should reflect the specific results you seek and the performance standards you are setting for the contractor.

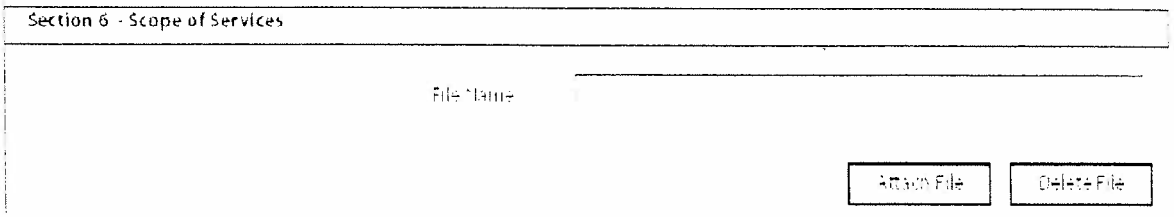


Figure 40 - Scope of Services Detail Attached

If you are unsure whether insurance is needed, what the insurance requirements are or if you do not have a current certificate to attach, select "No" for the Insurance Necessary attribute. Then make a note in the Action Log (Figure 55, page 29) drawing this item to the attention of Corporation Counsel.

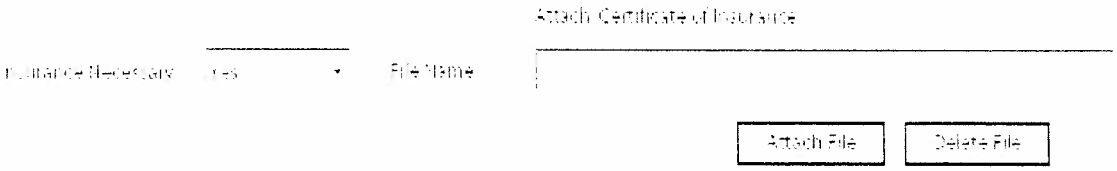


Figure 41 - Insurance Detail

Note – By selecting "Yes" to Insurance Necessary, you will be required to attach the Certificate of Insurance.

Section 7 – Contractor Information

If the vendor/contractor has previously worked for The City then they will have an assigned Vendor Number in MUNIS.

Enter the Vendor Number and click the [MUNIS VALIDATION] button. If the vendor has been setup properly and the number entered correctly, information about the vendor will be retrieved and displayed in the RFA form.

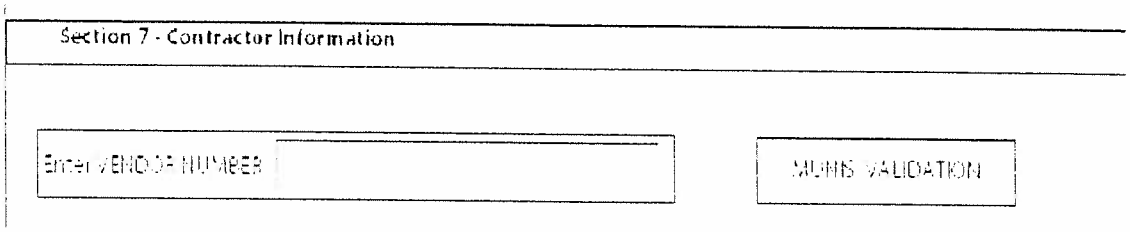


Figure 42 - MUNIS Validation

MUNIS validation is a requirement for all Requests for Agreement.

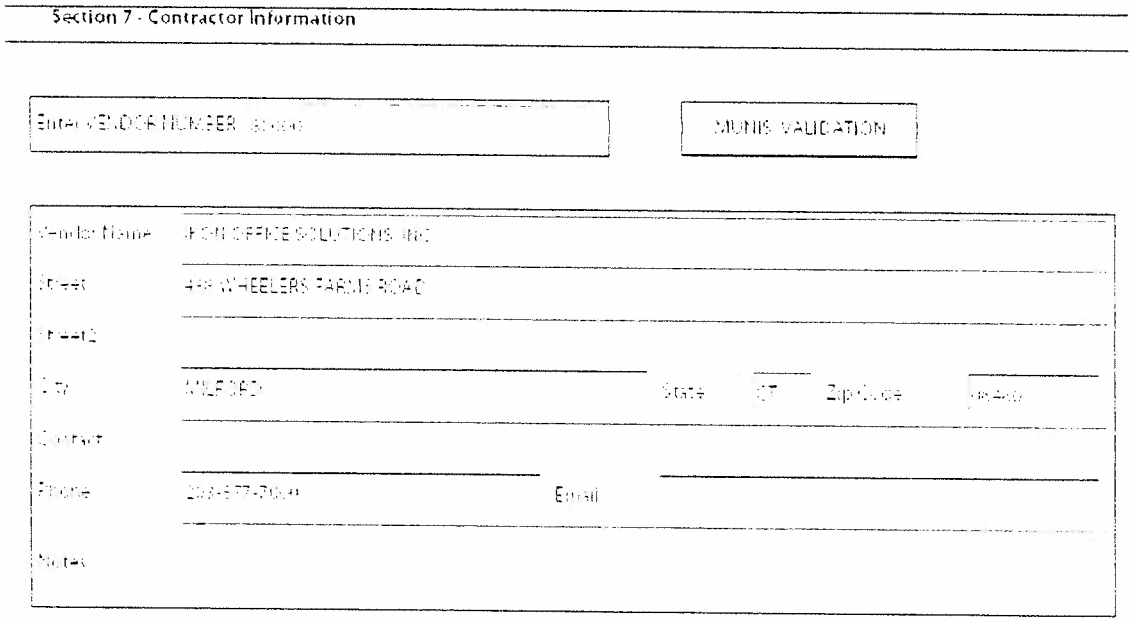


Figure 43 - Vendor Data from MUNIS

If the Vendor Number entered does not retrieve information from MUNIS check to see if the number you entered is correct.

If the Vendor is not setup in MUNIS, select the [Request Vendor Setup] button to initiate a new request. Refer to Vendor Add/Modify Workflow and Form beginning on page 35.

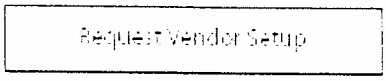


Figure 44 - Request Vendor Setup Button

Note – Requesting a New Vendor Setup will stop the current RFA until the new vendor setup is complete. The RFA will disappear from your work list. Once the new vendor has been added you can continue the RFA. It will reappear in your work list.

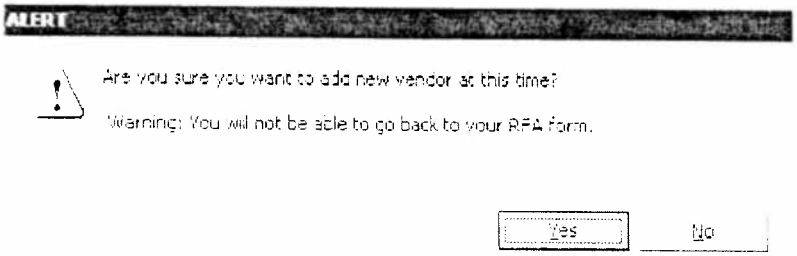
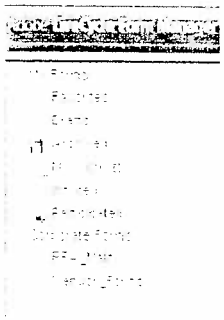


Figure 45 - New Vendor Setup Warning Dialogue

TIP – Plan Ahead! If you know the vendor is not setup in MUNIS, initiate the Vendor Setup form independently from the *Corporate Forms* list in the Form Manager. By doing the Vendor Add separately, you will not halt the RFA process midstream.



If the vendor information is retrieved but you notice the information is inaccurate or incomplete, select the [Request Vendor Update] button to initiate a correction or simply type a brief comment in the *Notes* section. The Finance Department will review and address your note.

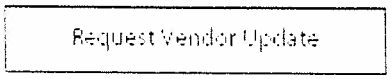


Figure 46 - Request Vendor Update Button

Note – Requesting a Vendor Update will not stop the current RFA. A Vendor Modification Form will be placed in your work list. Make any corrections or additions and submit it normally. An informational dialogue will appear at the bottom of the form.

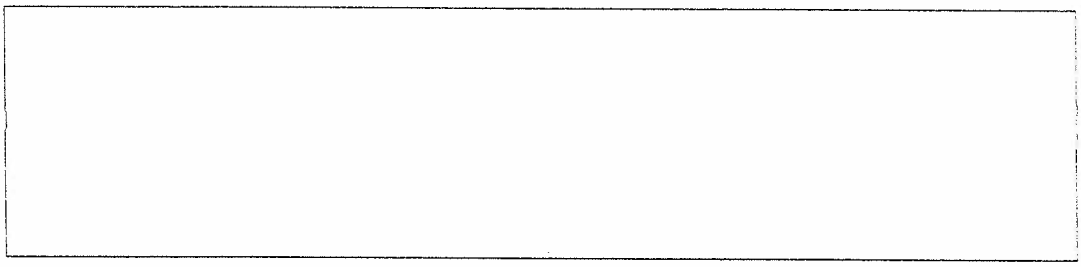


Figure 47 - Vendor Modification Information Dialogue

Section 8 – Maximum Compensation

Enter the compensatory amounts for the agreement.

Note – If the Type of Purchase selected involves an Amendment, these amounts will fill in automatically.

Figure 48 - Maximum Compensation Detail

Section 10 – Term of Agreement

Enter the Start and End Dates for the agreement.

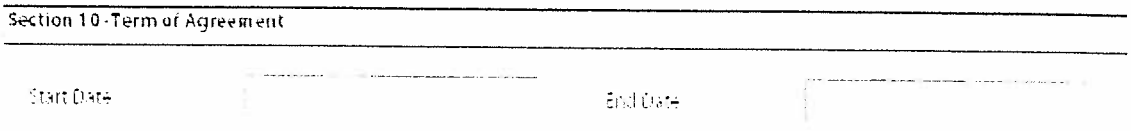


Figure 49 - Term of Agreement Detail

Start Date - Agreements cannot be backdated more than 30 days.

End Date – Agreements having General Funding cannot extend (have an End Date) beyond the current fiscal year.

Section 11 – Reporting Requirements

Indicate if this is applicable and what the frequency of reports will be i.e., monthly, quarterly, annually. The originating department will be responsible for making sure that required reports are received. Payments or future contracts may be held up if a vendor fails to supply reports.

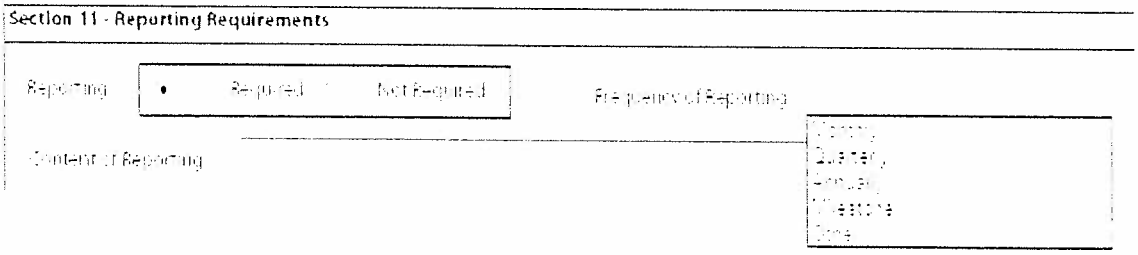


Figure 50 - Reporting Requirements Detail

Section 13 – Source of Funds

Provide the source of funds for the agreement. Enter the Fund Source (fund number) and Amount then click [ADD]. The number and amount will move to the columns on the right.

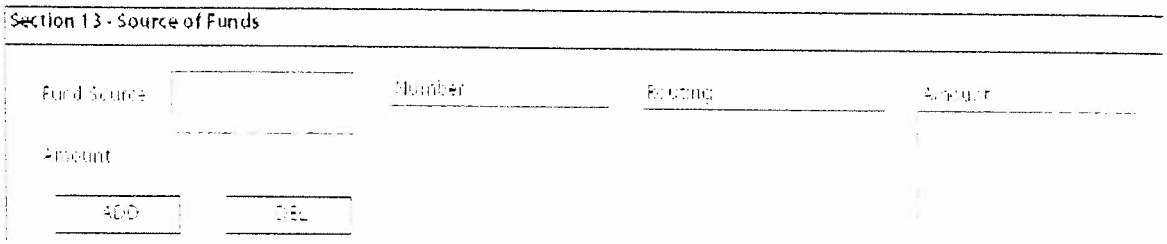


Figure 51 - Source of Funds Detail

The format of the fund number is specific. You will be warned if the number entered is not correct.

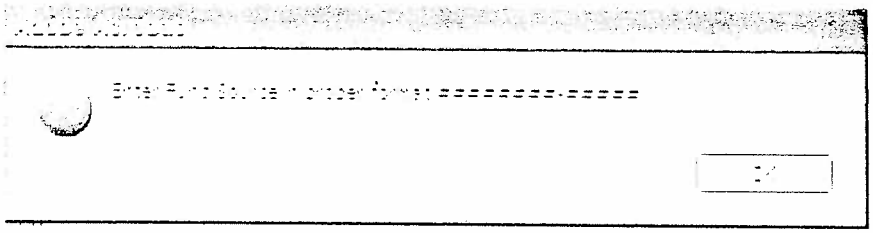


Figure 52 - Fund Number Formatting

A routing indicator will be shown indicating if approval is required from Accounting or Accounts Payable for the listed fund. This routing is informational. You do not need to contact the departments. The RFA will route to them automatically.

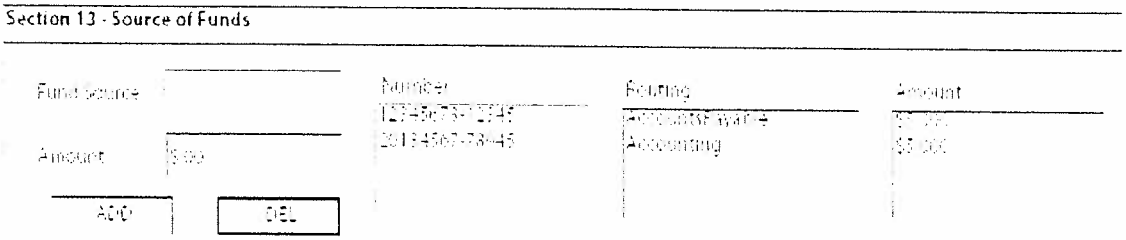


Figure 53 - Approval Routing Based on Fund Source

Multiple funding sources can be listed as needed however the total amount of funds allocated cannot exceed the total amount of the agreement.

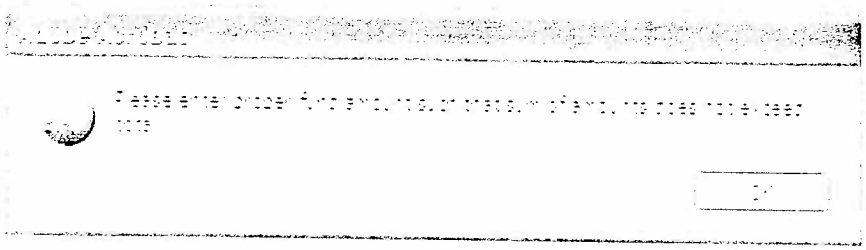


Figure 54 - Funding Allocation Warning

Action Log

For any additional information you feel will assist an approver or Corporation Counsel please indicate it briefly in the Action Log. You can also add attachments as needed.

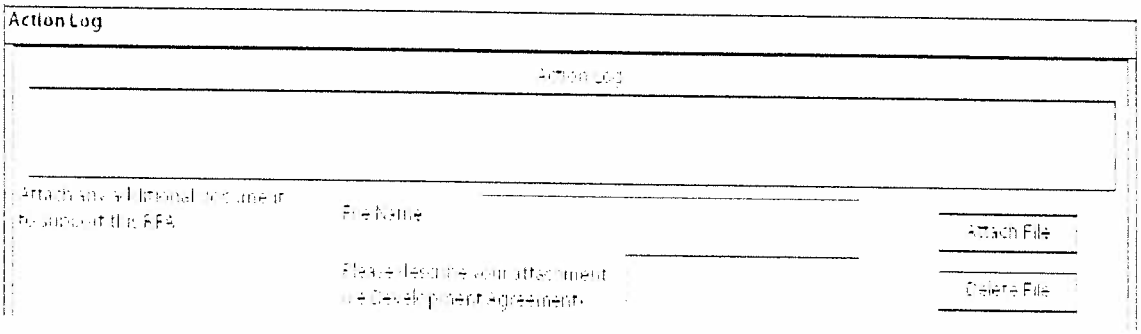


Figure 55 - Action Log

Section 14 – Vendor Affidavit

By City Ordinance no vendor who owes taxes or other financial obligations to the City can enter into contract and be paid for services. A Disclosure & Certification Affidavit (a.k.a. Form 1421) must be completed and attached. Affidavits are valid for a six-month period from August 1 to January 31 and from February 1 to July 31.

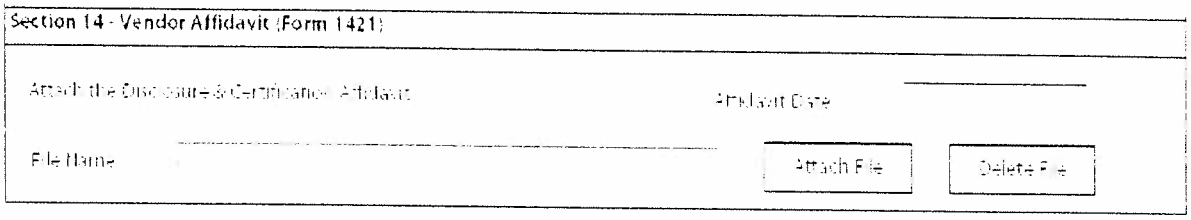


Figure 56 - Disclosure & Certification Affidavit Detail

Submitting the Form

Once all information has been completed and all supporting documentation attached the form can be submitted for approval routing.

Review the information for completeness and accuracy then click [Submit Request] at the bottom of the form.

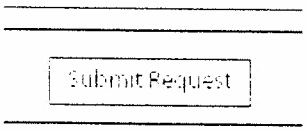


Figure 57 - [Submit] Button

Note – Upon click a series of business rule checks will be performed, e.g. start/end dates, board approval requirements, etc. Any rules that fail verification will cause a warning message to display. You will be directed to correct the error prior to submission.

Approving the Form

Each approver in the process is required to acknowledge his/her responsibility for the accuracy and completeness of information relative to his/her role in the workflow. This acknowledgement is obtained by checking the box and digitally signing the RFA.

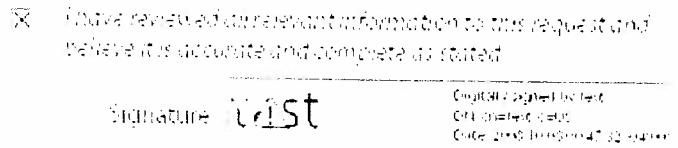


Figure 58 - Approver Acknowledgement and Signature

After signing the form, the Approver must Accept or Reject the RFA by choosing from the Action drop-down list. S/he then submits the action by clicking [Submit Request].

The Action is set to Accept by default. Should an approver choose to reject an RFA a reason for the rejection must be provided.

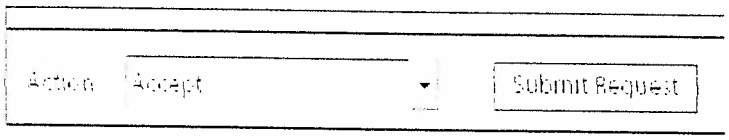


Figure 59 - Approve/Reject Action

Assessor's Office and Tax Collector Authorization

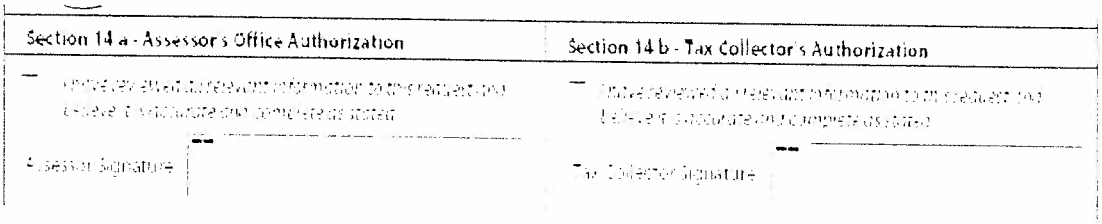


Figure 60 - Assessor and Tax Collector Authorization

Department Head Authorization

Section 15 - Department Head Authorization

☐ I have reviewed all relevant information to this request and believe it is accurate and complete as stated

Department Head Signature

Figure 61 - Department Head Authorization

Reviewed by Purchasing Department

Section 17 - Reviewed By Purchasing Department

☐ I have reviewed all relevant information to this request and believe it is accurate and complete as stated

Purchasing Department Signature

Figure 62 - Purchasing Authorization

Reviewed by Contract Compliance

Note – Review and approval by Contract Compliance is dependent on the Type of Purchase selected by the Originator. Not all RFA forms will be routed to Contract Compliance.

Section 18 - Reviewed By Contract Compliance

☐ I have reviewed all relevant information to this request and believe it is accurate and complete as stated

Contract Compliance Signature

Figure 63 - Contract Compliance Authorization

Reviewed by Accounting

Routing to Accounting is determined by the Funding Sources selected by the Originator. The routing portion of the Funding Source table will display whether or not the RFA will be routed to Accounting, see Figure 51 page 28.

If routing to Accounting is called for, then an Accounting resource will review the RFA, encumber the funds in MUNIS as usual and add the CAPO number to the form. If more than one Accounting Fund is called for then more than one CAPO should be created in MUNIS and entered into the RFA form.

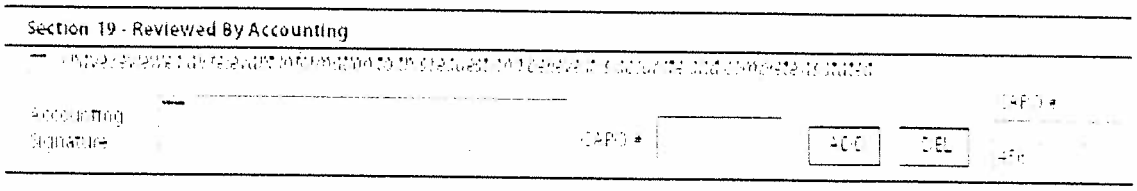


Figure 64 - Accounting Authorization

Note – If no routing to Accounting is indicated in Section 13 – Source of Funds the Accounting Authorization section may not be visible.

Reviewed by Accounts Payable

Routing to Accounts Payable is determined by the Funding Sources selected by the Originator. The routing portion of the Funding Source table will display whether or not the RFA will be routed to Accounting, see Figure 51 page 28.

If routing to Accounts Payable is called for, then an Accounts Payable resource will review the RFA, encumber the funds in MUNIS as usual and add the CAPO number to the form. If more than one Accounts Payable Fund is called for then more than one CAPO should be created in MUNIS and entered into the RFA form.

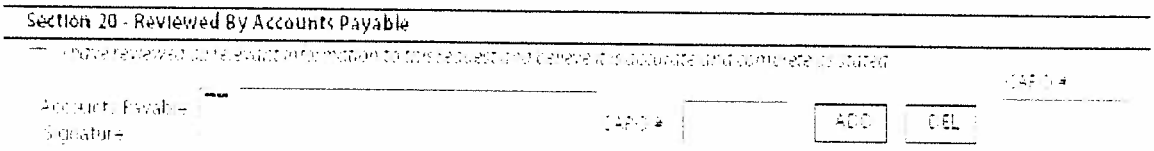


Figure 65 - Accounts Payable Authorization

Note – Depending on the routing shown in Section 13 – Source of Funds the Accounts Payable Authorization section may not be visible.

Controller Authorization

Section 21 - Controller Authorization

☐ *I have reviewed all relevant information to this request and believe it is accurate and complete as stated*

Controller Authorization

Figure 66 - Controller Authorization

Reviewed by Corporation Counsel

Upon arrival in the Corporation Counsel's work list an individual counsel person will be assigned and a contract number generated. Both will be indicated in the RFA form. Once finished and the agreement has been "inked" counsel will digitally sign the RFA and submitted.

Section 23 - Reviewed By Corporation Counsel

Counsel Assigned | Contract Number

☐ *I have reviewed all relevant information to this request and believe it is accurate and complete as stated*

Corporation Counsel

Figure 67 - Assignment to Counsel

This will conclude the Request for Agreement process.

VENDOR ADD/MODIFY WORKFLOW AND FORM

During preparation of the RFA the vendor number, name and contact information are validated against MUNIS, refer to Section 7 – Contractor Information beginning on page 23 for additional details. Should that validation fail, meaning that the vendor number entered by the originator does not exist in MUNIS, the originator will need to complete a Vendor Add/Modification Form. This same form can be used if the validation succeeds, but the information retrieved from MUNIS is incorrect or incomplete.

When the Vendor Add process is invoked, the current Request for Agreement is halted until addition is completed. Once MUNIS has been updated as necessary by Accounting, the RFA is released and the Originator can resume the request. When the Vendor Modification process is invoked, the Request for Agreement can continue normally (in parallel).

The Business Process

The Vendor Add/Modify process can be initiated from within the RFA form or on its own from the *Corporate Forms* folder in the Form Manager. Regardless of how it is initiated the business process is the same.

Upon completing the form, the Originator submits the form to the workflow server. Based on conditions in the form and the workflow rules, the workflow server will determine to whom the form is routed for approval. Forms will follow a process very similar to what is seen in Figure 68 below.

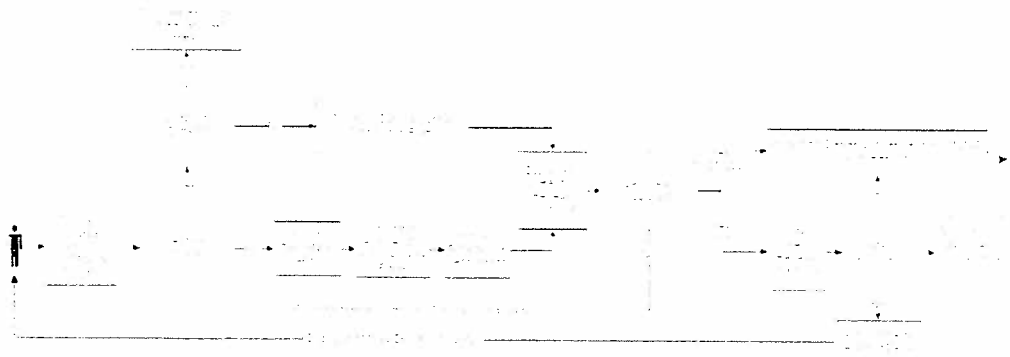


Figure 68 - Vendor Add/Modify Workflow

Completing the Form

Information needed to complete the form changes based on an Addition or Modification of the Vendor.

Request Vendor Setup

For additions, simply enter the information as needed to setup a new vendor in MUNIS.

Section 7 – Vendor Information

Section 7 - Vendor Information

Vendor Name	
Vendor DBA	
Correspondence Address	
Remittance Address	
Primary Contact	
Phone	
Email	
Federal ID#	

Figure 69 - New Vendor Detail Needed

Request Vendor Update

For modifications, simply correct or add to the information retrieved from the MUNIS validation.

Setting Up Employees As Vendors

In cases where City employees are setup as vendors, the Department and Employee Number are to be listed. This section is not to be used for traditional vendor setup.

This section for use only when adding/updating employees as vendors.

Employee Department

Employee Number

Figure 70 - Employees Setup as Vendors Details Needed

W9 Attachment

For all New Vendors an IRS Request for Taxpayer Identification Number and Certification (Form W9) is required.

File Name | Attach W9 Form | Delete W9 Form

Figure 71 - Attach W9 Form

Approving the Form

Each approver in the process is required to acknowledge his/her responsibility for the accuracy and completeness of information relative to his/her role in the workflow. This acknowledgement is obtained by checking the box and digitally signing the New Vendor Add form.

☒ I have reviewed all relevant information on this request and believe it is accurate and complete as stated

Signature Test

Figure 72 - Approver Acknowledgement and Signature

Department Head Authorization

Department Head Authorization

— I have reviewed all relevant information to this request and believe it is accurate and complete as stated

Department Head Signature

Figure 73 - New Vendor - Department Head Authorization

Tax Collector Authorization

For New Vendor Setup Tax Collector authorization is required. This step does not occur for Vendor Modifications.

Tax Collector Authorization

— I have reviewed all relevant information to this request and believe it is accurate and complete as stated

Tax Collector Signature

Figure 74 - New Vendor - Tax Collector Authorization

Accounting Authorization

In addition to acknowledging and signing the form, Accounting will further determine if a 1099 is necessary for this vendor. The new Vendor Number will also be entered.

Upon approval and submission of this form by Accounting a notification will be sent back to the originator indicating the new vendor's number.

Accounting Authorization

Set Up/Update complete | 1099 for Vendor

Accounting Signature | Vendor Number

Figure 75 - New Vendor - Accounting Authorization

From: Michael Fumiatti
To: alucas@newhavenct.net; amartine@newhavenct.net; arizzo@newhavenct.net;...
Date: 4/27/2010 4:18 PM
Subject: RFA System Upgrade

We will be upgrading to Adobe 9.0 on the RFA system - This is a completely new platform. The upgrade will take approximately 2 weeks. **SO PLEASE DO NOT ENTER ANY NEW RFA's effective immediately. 4/27/2010**

Please check your worklist for the next 24 hours as we will be moving existing RFA's through rapidly.

If you have any issues with RFA's in the meantime PLEASE contact me and I will do what I can.

Michael V. Fumiatti
Purchasing Agent
200 Orange Street Rm 301
New Haven, CT 06510
Tel: 203-946-8201 Fax: 203-946-8206
Website: www.cityofnewhaven.com/purchasingbureau

From: Michael Fumiatti
To: amartine@newhavenct.net; bpantel@newhavenct.net; carl.carangelo@new-ha...
CC: Felipe Pastore; Michael ONeil
Date: 8/24/2011 3:28 PM
Subject: RFA Compensation Form
Attachments: RFA Compensation Document.doc

Effective **Immediately** the attached form must be completed and attached to every RFA as a "PDF" document. corporation Counsel will no longer process the RFA if this is not included.

All RFA's submitted without this document will be rejected.

Anything in the system as of today's date, will be processed however if you know it would have required this form feel free to complete and forward to your attorney.

As always any questions or concerns, please feel free to contact me.

Michael V. Fumiatti
Purchasing Agent
200 Orange Street Rm 301
New Haven, CT 06510
Tel: 203-946-8201 Fax: 203-946-8206
Website: www.cityofnewhaven.com/purchasingbureau

City of New Haven
Request for Agreement (RFA)
Method of Compensation Schedule

This document is required for EVERY electronic RFA effective 8/25/2011

Vendor Name:	

Hourly Rate	Name	Title

Lump Sum Amount	Indicate when payment will be rendered

Progress Payments	Indicate amount and when payment will be rendered ie weekly, monthly, quarterly, % complete etc

Other	Please provide Detail

Not Applicable	Please provide Detail

Vendor provided documents can be included (indicate in the "Other" category and attach both docs to the RFA)

From: Michael Fumiatti
To: amartine@newhavenct.net; bpantel@newhavenct.net; carl.carangelo@new-ha...
Date: 10/3/2011 11:17 AM
Subject: Vendor Adds

The vendor add module in Adobe Livecycle is in full swing and working well.

We will be making an Administrative change to the process effective immediately.

Vendor adds will be accumulated by Accounting and processed by Close of Business every Tuesday ONLY!!!. Anyone who thinks this does not apply to you...it does!

SO please plan you needs accordingly. Any questions, concerns or comments, Please feel free to contact me
Thank you

Michael V. Fumiatti
Purchasing Agent
200 Orange Street Rm 301
New Haven, CT 06510
Tel: 203-946-8201 Fax: 203-946-8206
Website: www.cityofnewhaven.com/purchasingbureau

From: Sal DeCola
To: MUNIS - Finance Anouncements; MUNIS_USERS; MUNISUSERSBOE; NH EMPLOYEE...
Date: 10/12/2010 9:30 AM
Subject: Encumbrance Purchase Order Entry into MUNIS

To everyone that enters Requisitions, Purchase Orders, Contracts, Agreements etc. into the MUNIS finance system.

When entering any of the above mentioned items into MUNIS and you are using more than one funding source please make sure you enter each funding source as an individual line. DO NOT enter the total dollar amount on the front page and split up the funding on one line.

It has been brought to my attention that the purchase orders are not liquidating properly when dividing the costs between multiple lines when entering using only one line only. From here forward any multiple charged encumbrances, etc, that are entered on a one line basis, and discovered by this department, will be canceled and you will be instructed to re-enter them properly.

Thank you,.

REQUEST FOR AGREEMENT AUTOMATION PROJECT

July 2009

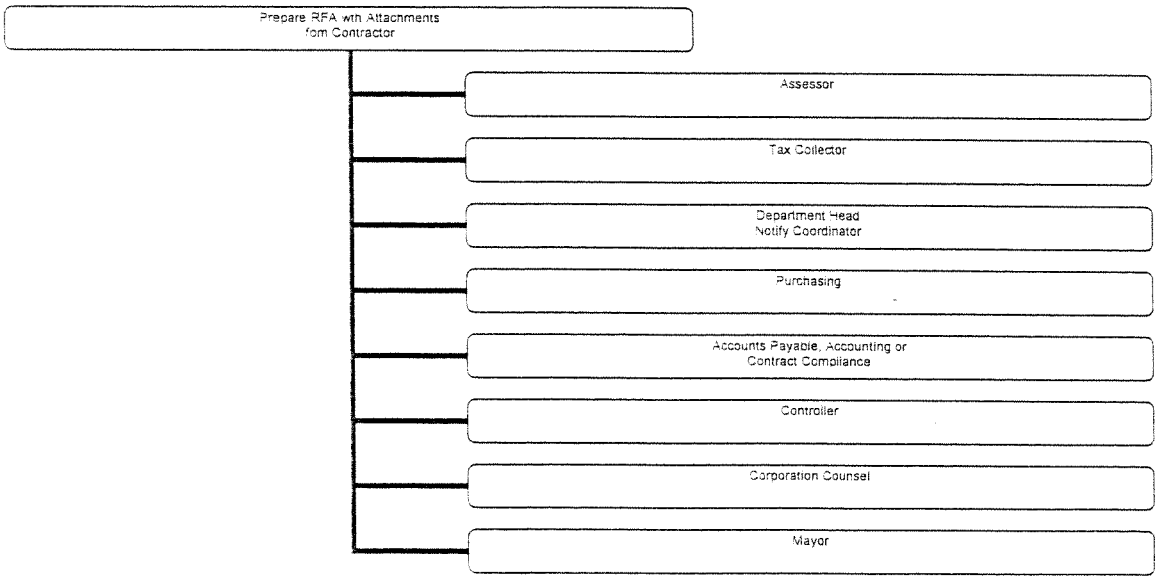
OVERVIEW

The Request for Agreement (RFA) Automation Project is an effort by The City of New Haven Bureau of Purchases to improve an existing paper-based contract process through implementation of an intelligent document workflow system.

Rather than assembling paper documents and completing the RFA form with ink, the Originator ("Department") will complete an interactive portable document form ("PDF") and upload attachments to it. This is beneficial as most of the attachments are within the city's control. Inherent in the new electronic form will be structure, validation and rules that will not allow the department to advance through the process without the necessary conditions being met. For those supporting documents that are not received in a digital format, they will need to be scanned using one of the city's existing scan-enabled multi-function devices.

WORKFLOW

Upon completing the RFA form, the department submits the form electronically. The form is routed to the appropriate department for approval based upon certain conditions and workflow rules inherent in the format of the RFA. The RFA will follow a process very similar to what is seen below:



For each advancement step of the RFA approval process, a simple email notification will be sent back to the department.

CORPORATION COUNSEL

Upon receipt of the RFA form in Corporation Counsel, Pam Popolizio will open a file on Citylaw, assign a number to the RFA form and upload the RFA form and the attachments to the Citylaw Assignment file. An email notification from Pam will be sent to the appropriate attorney letting him/her know that the RFA was assigned to him or her so that they or a staff person may begin to draft the contract.

The number of paper originals of the contract have changed to 2. Pam Popolizio will forward two (2) paper originals, NOT five, of the final contract to the department for the Contractor's signature. Upon return and final execution by the Mayor, the two executed paper originals are processed and uploaded onto Citylaw by Pam. The Contractor shall receive an executed paper original of the contract and Corporation Counsel shall maintain an executed paper original of the contract. Pam will forward electronic original copies to the Department, Town Clerk, and Accounts Payable.

For security purposes, in Pam's absence, a password will be given to a designated member of Corporation Counsel, or such other process will be instituted as deemed appropriate.

Thank you.

REQUEST FOR AGREEMENT (RFA) AUTOMATED PROCESSING

Using Adobe LiveCycle & City Law

As of July 2009

1. Enter Adobe LiveCycle with the following:
   User: ppopoliz/Password: xxxxxxx

2. Select the word Worklist

3. Select +

4. Select Counsel Approval

5. Select Checkmark

6. Highlight Purpose from Section 4 of RFA, Right Click & Copy Contents

7. Review Contractor Name & Amount Information (you may wish to write this information on separate note pad)

8. Enter Citylaw & Open Assignment Module

9. Enter Contractor Name & Amount Information in Citylaw (with other information)

10. Paste the Purpose from the RFA in the Description Section in Citylaw (Ctrl-V)

11. Write the Citylaw # & Assigned Attorney on separate note pad

12. Go back to RFA, Section 22A and locate Pamela Popolizio under Counsel Assigned Section & Enter Citylaw # in Contract # Section

13. Select Submit Request on RFA (Do Not fill-in Section 22B at this point!)

14. Select the word Worklist

15. Select RFA

16. Select & change Section 22A from Pamela Popolizio to the actual Attorney Assigned to the RFA

17. At Section 22B, Select the Checkmark and Sign (Pamela Popolizio's name should appear—use her password xxxxxx)

18. Select Save (ikon located at top left of RFA document) RFA in My Documents

19. Name RFA as: RFA.A09.XXXX

20. Select Submit Request on RFA

21. Go back to Citylaw, Section Other Files, Import RFA

22. Select Email Log in Citylaw & Hit New to Send the Assigned Attorney a quick note that a new RFA has been assigned to them (Do Not attach the actual RFA to the email because it is already saved in Citylaw!)

Request for Agreement

RFAID # 20090706.PUR.10020

Priority Normal

Section 1 - Date and Department Information

Department Name: Bureau of Purchases

Request Date: Thu, July 16, 2009 9:38:38 AM

Section 2 - City Contact Information

Requested By: Michael Fumiatti

Email: MFumiatt@newhavenct.net

Phone: 946-8207

Section 3 - Agreement Type

Agreement Type: Professional Service

Section 4 - Purpose

Purpose of Agreement: WORKER'S COMP CLAIMS ADMINISTRATION

Section 5 - Type of Purchase

- Bureau of Purchases - 5A
- Non-purchasing Selection Process - 5B
- Revenue Agreement - 5C

Section 5a - Bureau of Purchases

Purchasing Method:
- Request for Proposal
- Exempt Professional
- Sole Source
- Amendment

RFP Number: 27-01-515

Attach RFP Document Here:

File Name: 2007 Total Mgt_1. Workers Compensation P

Attach File | Delete File

Section 6 - Scope of Services

File Name: CIRMA SOS reference.pdf

Attach File

Attach Certificate of insurance

Insurance Necessary: Yes

File Name: COI-CIRMA.pdf

Attach File | Delete File

SAMPLE

Request for Agreement

Section 7 - Contractor Information

Enter VENDOR NUMBER	20620

Vendor Name :	CONNECTICUT INTERLOCK RISK MANAGEMENT				
Street :	900 CHAPEL STREET				
Street2 :					
City :	NEW HAVEN	State :	CT	Zip Code :	06510
Contact :					
Phone :		Email :			
Notes :					

Request for Agreement

Section 8 -Maximum Compensation

Amount	$550,000.00	Total Amount	$550,000.00

Section 9 -Compensation

Method of Compensation

- Method of Compensation: Receipt of Payment

Payment Method: Check

Payment Frequency: Monthly

Section 10 -Term of Agreement

Start Date	Jul 1, 2009	End Date	Jun 30, 2010

Section 11 - Reporting Requirements

Section 13 - Source of Funds

Fund Source	Number	Routing	Amount
	18028530-56694	AccountsPayable	$550,000

Amount: $.00

ADD DEL

Action Log

Action Log

Prepared for Dan Roche by Michael Fumiatti

Attach any additional document to support this RFA.

File Name : CIRMA CAPO.pdf

Attach File

Please describe your attachment (i.e Development Agreement): Contract Rates

Delete File

Section 14 - Vendor Affidavit (Form 1421)

Attach the Disclosure & Certification Affidavit

Affidavit Date: Jul 1, 2009

File Name : CD-CIRMA.pdf

Attach File Delete File

Request for Agreement

Section 14 a - Assessor's Office Authorization

✓ *I have reviewed all relevant information to this request and believe it is accurate and complete as stated.*

Assessor Signature: Bill O'Brien — Digitally signed by Bill O'Brien DN: cn=Bill O'Brien, c=US, o=City of New Haven, ou=Department Of Assessment, email=Wobrien@newhavencity.net Date: 2009.07.06 11:45:25 -04'00'

Section 14 b - Tax Collector's Authorization

✓ *I have reviewed all relevant information to this request and believe it is accurate and complete as stated.*

Tax Collector Signature: Rose Vega — Digitally signed by Rose Vega DN: cn=Rose Vega, c=US, o=City of New Haven, ou=Office of the Tax Collector, email=vega@newhavenct.net Date: 2009.07.07 10:13:43 -04'00'

Section 15 - Department Head Authorization

✓ *I have reviewed all relevant information to this request and believe it is accurate and complete as stated.*

Department Head Signature: Michael V. Fumiatti — Digitally signed by Michael V. Fumiatti DN: cn=Michael V. Fumiatti, c=US, o=City of New Haven, ou=Bureau of Purchases, email=mfumiatt@newhavenct.net Date: 2009.07.07 11:09:06 -04'00'

Section 17 - Reviewed By Purchasing Department

✓ *I have reviewed all relevant information to this request and believe it is accurate and complete as stated.*

Purchasing Department Signature: Michael V. Fumiatti — Digitally signed by Michael V. Fumiatti DN: cn=Michael V. Fumiatti, c=US, o=City of New Haven, ou=Bureau of Purchases, email=mfumiatt@newhavenct.net Date: 2009.07.07 11:12:47 -04'00'

Section 18 - Reviewed By Contract Compliance

Section 19 - Reviewed By Accounting

Section 20 - Reviewed By Accounts Payable

✓ *I have reviewed all relevant information to this request and believe it is accurate and complete as stated.*

Accounts Payable Signature: Arami Martinez — Digitally signed by Arami Martinez DN: cn=Arami Martinez, c=US, o=CITY OF NEW HAVEN, ou=ACCOUNTS PAYABLE, email=amartine@newhavenct.net Date: 2009.07.07 14:19:26 -04'00'

CAPO # 20101053 ADD DEL

CAPO #

Section 21 - Controller Authorization

✓ *I have reviewed all relevant information to this request and believe it is accurate and complete as stated.*

Controller Authorization: Mark Pietrosimone — Digitally signed by Mark Pietrosimone DN: cn=Mark Pietrosimone, c=US, o=Finance, ou=Finance Date: 2009.07.08 09:48:08 -04'00'

Section 22 a - Reviewed By Corporation Counsel

Counsel Assigned: Felipe Pastore III

Contract Number: A09-0646

Section 22 b

I have reviewed all relevant information to this request and believe it is accurate and complete as stated.

Corporation Counsel

Action: Accept

Submit Request

ACORD. CERTIFICATE OF LIABILITY INSURANCE

OP ID SB CONNC-1 | DATE (MM/DD/YYYY) 06/29/09

PRODUCER
CDR Insurance Group, Inc.
211 Schraffts Drive
Waterbury CT 06705
Phone: 203-754-3156 Fax: 203-754-7927

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED

Ct.Conferenceof Municipalities
& Ct Interlocal Risk Mgt Agncy
900 Chapel Street
New Haven CT 06510

INSURERS AFFORDING COVERAGE		NAIC #
INSURER A:	General Casualty	24414
INSURER B:	Hartford Insurance Company	22357
INSURER C:	Travelers Property Casualty	
INSURER D:		
INSURER E:		

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A		GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC	CCS0356153	06/30/09	06/30/10	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG Emp Ben.	$ 1,000,000 $ 1,000,000 $ 10,000 $ 1,000,000 $ 2,000,000 $ 1,000,000 1,000,000
A		AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS	CBA0356153	06/30/09	06/30/10	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
		GARAGE LIABILITY ANY AUTO				AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY: EA ACC AGG	$ $ $
A		EXCESS/UMBRELLA LIABILITY X OCCUR CLAIMS MADE DEDUCTIBLE RETENTION $	CCU0356153	06/30/09	06/30/10	EACH OCCURRENCE AGGREGATE	$ 10,000,000 $ $ $ $
B		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	31WBD2506	06/30/09	06/30/10	X WC STATUTORY LIMITS OTHER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 100,000 $ 100,000 $ 500,000
		OTHER					
C		FIDELITY	457PB0919	06/30/09	06/30/10	FIDELITY	$1,250,000
C		FIDUCIARY LIAB	ECO5700183	06/30/09	06/30/10	FIDUCIARY	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

SUBJECT TO A WRITTEN AGREEMENT IN EFFECT, CERTIFICATE HOLDER IS ADDITIONAL INSURED ON GENERAL LIABILITY POLICY FOR OPERATIONS CONDUCTED BY THE NAMED INSURED IN THE ADMINISTRATION OF THEIR WORKERS COMPENSATION AND HYPERTENSION CLAIMS.

CERTIFICATE HOLDER

CTYOFNH

City of New Haven
Mr. Daniel Roche
W.C. Coordinator
200 Orange St., 3rd Floor
New Haven, CT 06510

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
CDR Insurance Group, Inc.

© ACORD CORPORATION 1988

THE CITY OF NEW HAVEN

BUREAU OF PURCHASES

200 Orange Street

New Haven, Connecticut 06510
(203) 946-8201 - FAX (203) 946-8206

JOHN DeSTEFANO, JR.
Mayor

Michael V. Fumiatti
Purchasing Agent

DISCLOSURE & CERTIFICATION AFFIDAVIT OF OUTSTANDING OBLIGATIONS TO THE CITY OF NEW HAVEN

VENDOR NAME	Connecticut Interlocal Risk Management Agency "CIRMA"
VENDOR ADDRESS	900 Chapel Street, 9th Floor, New Haven, Connecticut 06510
TELEPHONE /FAX	203-946-3700 / 203-773-6971
CONTACT/E-MAIL ADDRESS	DAVID DEMCHAK, VICE PRESIDENT, DDEMCHAK@CCM-CT.ORG
SOLICITATION TITLE	
SOLICITATION NUMBER	

For the purposes of this Disclosure of Outstanding Financial Obligations, the following definitions apply:

(a) "Contract" means any Public Contract as defined below.

(b) "Person" means one (1) or more individuals, partnerships, corporations, associations, or joint ventures.

(c) "Public Contract" means any agreement or formal commitment entered into by the city to expend funds in return for work, labor, services, supplies, equipment, materials or any combination of the foregoing, or any lease, lease by way of concession, concession agreement, permit, or per agreement whereby the city leases, grants or demises property belonging to the city, or otherwise grants a right of privilege to occupy or to use said property of the city.

(d) "City" means any official agency, board, authority, department office, or other subdivision of the City of New Haven.

State of	Connecticut	County of	New Haven	Ss.
Bruce A. Wollschlager				being first duly sworn, deposes and says that:
(type or print your name above)				

1.	I am owner, partner, officer, representative, agent or _____ of:	Connecticut Interlocal Risk Management Agency "CIRMA"
	(circle one)	Company Name (if individual type your name)

2.	I am fully informed respecting the preparation and contents of the attached Agreement and of all pertinent circumstances respecting such Agreement;

3.	That as a person desiring to contract with the City (check all that apply):
	The Contractor and each owner, partner, officer, representative, agent or affiliate of the Contractor has filed a list of taxable personal property with the City of New Haven for the most recent grand list, as required by Conn. Gen. Stat. §12-42.
	Neither the Contractor nor any owner, partner, officer, representative, agent or affiliate of the Contractor are required to file a list of taxable personal property with the City of New Haven for the most recent grand list, as required by Conn. Gen. Stat. §12-42.
	Neither the Contractor nor any owner, partner, officer, representative, agent or affiliate of the Contractor either directly or through a lease agreement, owes back taxes to the City of New Haven
X	Neither the Contractor nor any owner, partner, officer, representative, agent or affiliate of the Contractor either directly or through a lease agreement, has any other outstanding obligations to the City of New Haven
	The Contractor or an owner, partner, officer, representative, agent or affiliate of the Contractor owes back taxes and has executed an agreement, satisfactory to the tax collector, to pay said back taxes in installment payments and the payments under said agreement are not in default. The agreement shall be attached, and incorporated herein by reference.

4. The following list is a list of the names of all persons affiliated with the business of the Contractor, if none state none. Use additional sheet if necessary (Must be on company letterhead and notarized): This does not mean ALL employees - just officers, owners etc.

	Name	Title	Affiliated Company (if none state NONE)	Service or Material	DOB
1	Bruce A. Wollschlager	President & CEO	None	Service	08/24/1951
2	Steve Bixler	Asst. Secretary	None	Service	01/18/1954
3	Frank Coulom, Jr.	Secretary	None	Service	05/21/1954
4	Stuart English	Treasurer	None	Service	01/02/1941
5	See Attached list of CIRMA Board of Directors				

5. That as a person desiring to contract with the City:

(a) The Contractor or an owner, partner, officer, representative, agent or affiliate of the Contractor provides, or has provided, services or materials to the City within one (1) year prior to the date of this disclosure, if none, state none. Use additional sheet if necessary (Must be on company letterhead and notarized):

	Name	Title	Affiliated Company (if none state NONE)	Service or Material	DOB
1	Same as listed in 4 above.				
2					
3					
4					

(b) The Contractor possesses an ownership interest in the following business organizations, if none, state none. Use additional sheet if necessary (Must be on company letterhead and notarized) :

	Organization Name	Address	Type of Ownership		
1	None				
2					

(c) The following persons possess an ownership interest in the Contractor. If the Contractor is a corporation, list all of the officers of the corporation and the names of each stockholder whose shares exceed twenty-five (25) percent of the outstanding stock, if none, state none. Use additional sheet if necessary (Must be on company letterhead and notarized):

	Name	Title	DOB	Stock %	
1	None				
2					

(d) Of the following of the affiliates, individuals or business entities identified in this affidavit, list each that owns, owned, or within one (1) year prior to the date of this disclosure has owned, taxable property situated in the City of New Haven, if none state none. Use additional sheet if necessary (Must be on company letterhead and notarized):

	Name	Title	Affiliated Company (if none state NONE)	Address	DOB
1	None				
2					

(e) If the Contractor conducts business under a trade name, the following additional information is required: the place where such entity is incorporated or is registered to conduct such business; and the address of its principal place of business, if none, state none:

	TRADE NAME	PLACE OF INCORPORATION/REGISTRY	PRINCIPAL PLACE OF BUSINESS
1	None		
2			

I hereby certify that the statements set forth above are true and complete, and I understand that any incorrect information or omission of information from this affidavit may result in the immediate termination of the Contractor's agreement with the City of New Haven.

(Signed) Bruce A. Wollschlager

Bruce A. Wollschlager Title: President and CEO, CIRMA

Subscribed and sworn to before me this 26th day of June, 2009.

Notary Public Susan B Landon
(Title)

SUSAN BRADFORD LANDON
NOTARY PUBLIC
MY COMMISSION EXPIRES DEC. 31, 2012

My commission expires Dec 31, 2012.

This Form Must be Notarized

CIRMA
Member Owned
Member Governed

CONNECTICUT INTERLOCAL RISK MANAGEMENT AGENCY

900 Chapel Street, 9th Floor
New Haven, CT 06510-2807
Telephone: 203-946-3700
Fax: 203-773-6971
www.cirma.org

CIRMA Board of Directors

Timothy C. Griswold
Chairman
First Selectman, Old Lyme

Michael P. Stupinski
Vice Chairman
First Selectman, Ellington

Martin Berliner
City Manager, New London

Ryan Bingham
Mayor, Torrington

Woody Bliss
First Selectman, Weston

Mark D. Boughton
Mayor, Danbury

Susan Bransfield
First Selectwoman, Portland

Stephen T. Cassano
Selectman, Manchester

Frank J. Chiaramonte
First Selectman, Harwinton

Melody A. Currey
Mayor, East Hartford

John DeStefano, Jr.
Mayor, New Haven

John Elsesser
Town Manager, Coventry

Matthew B. Galligan
Town Manager, South Windsor

Sebastian Giuliano
Mayor, Middletown

Mary Glassman
First Selectwoman, Simsbury

Cynthia Mangini
Council Member, Enfield

Michael Pace
First Selectman, Old Saybrook

Elizabeth C. Paterson
Mayor, Mansfield

David A. Pinney
First Selectman, Somers

Herbert C. Rosenthal
Selectman, Newtown

Philip K. Schenck, Jr.
Town Manager, Avon

Peter Tesei
First Selectman, Greenwich

John Weichsel
Town Manager, Southington

Steven Werbner
Town Manager of Tolland

Bruce A. Wollschlager
President and
Chief Executive Officer

I hereby certify that this is the true and complete listing of CIRMA Board of Directors as of this day.

Bruce A. Wollschlager

Bruce A. Wollschlager, President and CEO

Subscribed and sworn to before me on this 26th day of June, 2009.

Susan B Landon, Notary Public

SUSAN BRADFORD LANDON
NOTARY PUBLIC
MY COMMISSION EXPIRES DEC. 31, 2012

A Service Program Of
CONNECTICUT CONFERENCE OF MUNICIPALITIES
THE VOICE OF LOCAL GOVERNMENT

CONTRACT/AGREEMENT PURCHASE ORDER:

CONTROLLER'S OFFICE
(203) 946-8300
200 ORANGE STREET - 3RD FLOOR
NEW HAVEN, CT 06510

CONTRACT/AGREEMENT PURCHASE ORDER # 20101053-00 FY 2010
Page Number: 1

CITY OF NEW HAVEN
DEPARTMENT OF FINANCE
200 ORANGE STREET, NEW HAVEN, CT 06510

VENDOR
CONNECTICUT INTERLOCK RISK MANAGEMENT
900 CHAPEL STREET

NEW HAVEN, CT 06510

SHIP TO
CONTROLLER'S OFFICE
(203) 946-8300
200 ORANGE STREET - 3RD FLOOR
NEW HAVEN, CT
06510

Delivery Reference
DAN ROCHE

DATE ORDERED	VENDOR NUMBER	DATE REQUIRED	FREIGHT METHOD/TERMS	DEPARTMENT/LOCATION
07/07/09	020620		FOB NEW HAVEN	DEPT OF FINANCE

BY	INVOICE NUMBER (S)	DATE PROCESSED	AMOUNT LIQUIDATED	AVAILABLE BALANCE
	WORKER'S COMP CLAIMS ADMINISTRATION 07/01/09-06/30/2010 RFP 27-01-515 18058530-56694 550,000.00 PO Expiration Date 06/30/2010 ATTENTION VENDORS - Please register on our website to be notified by email of upcoming solicitations. Log onto www.cityofnewhaven.com/purchasingbureau	1.0 EA	550000.00000 PO Total	550,000.00 - 550,000.00

Signed: _____
City Controller

CityLaw Litigation Case Management and Administrative Support System

CityLaw was created specifically for the local government law department.
The system is currently installed in local government law departments nationwide.

CityLaw consists of various integrated modules.

- **Litigation Case Management**
  Monitors Lawsuits, Case Calendars, and Case Status. Provides ready access to basic case information, case status, involved parties, opposing attorneys, calendar, and financial information. Automatically generates case calendar entries based on flexible user definitions.

- **Assignment Tracking**
  Manages and Tracks legal service requests submitted by client departments. Provides easy reference to work in progress, as well as, completed work. Provides for staff calendars, workload statistics and access to work product.

- **Liability Claims Management**
  Designed to support the local government claims process. Prepares common letters and notices and assists in timely completion of routine tasks. Produces a wide variety of risk management reports.

- **File Management**
  A central filing system designed for managing various types of office records with one reference method. Interfaces with other modules by providing one access point to all CityLaw records.

- **Time Accounting**
  Captures time and bills when appropriate. Time charges are related directly to specific cases and advisory assignments.

CityLaw is a custom installed system.

All modules are tailored to the specific priorities and concerns of each office. By customizing the system we ensure that the system meets the diverse needs of each law department. Modules are expanded and enhanced as necessary.

CityLaw is a trademark of CYCOM Data Systems, Inc.

CYCOM

Data Systems, Inc.

P.O. Box 92437
Long Beach, CA 90809-2437

888-CYCOM88
(888-292-6688)

CITYLAW FOR WINDOWS

System-Wide Features

- System Codes are maintained and modified by your System Administrator so that the codes specific to your office are available.

- A complex set of search criteria can be used to retrieve records.

- Individual Windows, such as the search list, can be moved so that you can view areas of the screen otherwise hidden from view.

- Standard Windows functions can be used in CityLaw, for example:
  CTRL + C will copy highlighted text to the clipboard
  CTRL + V will paste copied text into a document or field.

File Management

- Double clicking on a record listed on the Contents Tab allows you to open that record in the corresponding system module.

- You have the option to use the same numbering system in Litigation or Assignments as in File Management. You may otherwise have a completely different numbering scheme.

Calendar

- The Calendar gives you the ability to Assign entries to multiple staff members.

- Various View and Print Functions allow you to access calendar information in your preferred format.

- Navigation features allow you to view a specific day, week, or month for an individual record, staff person or team.

- The filter allows you to view and print by Appointment, Due and Tickler.

Word Processing

- Copying and Importing Capabilities allow you to use the format of an old document for a new record by simply modifying data specific to the current record.

- The Document List Allows you to maintain and print a complete list of all documents sent and received.

- You can manually change the sequence numbers of items on the document list with the Edit button.

Party Information

- A database of people allows you to enter and modify information such as an address or phone number and view the current information on all related records.

- Party searching allows you to retrieve all records associated with an individual. This is useful for attorney conflict of interest issues as well as tracking multiple claims by plaintiffs.

Data Entry

- While using the mouse allows you to take advantage of Windows capabilities, alternate keyboard functions are useful for quick data entry.

- Drop lists provide you with all valid codes for each field. Codes may be typed directly in the field or selected from the drop list.

- The Review information indicates how long since the record has been updated or reviewed. This is helpful for keeping all office matters up to date.

- Help features allows you to access on-line system information specific to the module you are using.

CITYLAW FOR WINDOWS

System Basics

After opening CityLaw for Windows, a toolbar will appear at the top of your screen.

As you move the cursor over each button with the mouse, you will see the name of the option next to each button. If you will not be using a particular option that button will not appear on your toolbar.

Click once on the button for the module you want to use.
File Management, Litigation, Assignments or Liability Claims

The following options will then appear at the bottom of the screen.

Click once on New to enter a new record, or click Search to look for an existing record. The Print and Reports options are not available until one or more records are retrieved.

Use the tabs to view different screens of information:

Use this button bar to access the Basic Screen, Case Calendar, Word Processing, and Graphics:

The Calendar can also be accessed from the CityLaw Toolbar at the top of the screen. These options bring up your personal calendar, or the calendar for a specific staff member or team.

Reference Page

CityLaw/CountyLaw is a Windows based application. Alternating between the mouse and keyboard functions, quick data entry can be achieved.

Mouse Commands

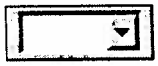
Copy, Cut, or Paste can be quickly done by clicking on the right-hand mouse button. In some cases, you may also Delete.

Keyboard Shortcuts

Cut -	CTRL + X
Copy -	CTRL + C
Paste -	CTRL + V

Saving Data

If the system does not prompt or show a **SAVE** button, then the data will automatically be saved. For example, when moving around different Tabs in a matter or screens, unless otherwise prompted, any changed data will be saved.



Drop List Arrows

Click on the Drop Arrow to display all valid codes for a particular field.

Ellipsis Button

Click on the Ellipsis Button to display different choices for a particular field.

Magnify Glass

Located at the top right hand corner of the screen. If double-clicked, it will reveal your last Search Results screen.

Browse

Located in the lower, right-hand corner of the Status Line. Point and right-click on the word Browse and it will allow you to Undo or Edit your last entry.

Litigation Case Management

Litigation

Basic | Description | Risk Mgmt | File Management

Title: Dew Drop Inn, Inc.

File #: L99-0002
Attorney: SAB
Attorney: ABC
Team: L
Staff: DMM
OS Counsel:
Investigator: CAS

Type: D
Cat: T
Cause: 0101
Track: H

Status: Closed 08/15/1999
Disposition: For Plaintiff 08/10/1999
Cross Ref: Dew Drop Inn, Inc.
Court: SUP SO323292393

Open Dt: 10/01/1998
Incident: 01/16/1998
Filed: 09/25/1998
Served: 09/27/1998
Assigned: 10/02/1998

Review: SAB
Date: 08/09/1999

Agncy: POL — POL: Police
Div: 000102 — 000102: General Fund
Short Desc: Excessive force.

Evaluation | Equipment | Keywords

New | Search | Print | Reports | Utility | Help | Close

L99-0002 | Dew Drop Inn, Inc. | edit

Litigation Search Criteria

Enter any criteria to filter and select desired Litigation files.

Search Selection: Base | People

Partial Match

File #

Status ++
Cat ++
Type ++
Attorney ++
Team ++
Staff ++
Court No
Cause ++
Track ++
Agncy ++
Div ++

Search words: + + or + +

Found in: Title, Status Desc, Keyword, Abstract Desc, Disposition Notes, Short Desc, Location, Location Code

Lookup Dates:	from	to
Open Dt	/ /	/ /
Incident	/ /	/ /
Filed	/ /	/ /
Served	/ /	/ /
Assigned	/ /	/ /
Review	/ /	/ /
Disposition	/ /	/ /

Search | Clear | Help | Saved | Cancel

Include history

Liability Claims

Claim

Basic | Description | Risk Mgmt | File Management

Title: Arnold, Joseph

File # 99-C0001
Attorney
Attorney
Team C
Staff DMM
OS Counsel
Investigator RAS

Type L
Cause 0501
Cat A
Track N

Status Open - Inproces 10/11/1999
Disposition # / /
Cross Ref
Jurisdiction M

Open Dt 10/11/1999
Incident 07/13/1999
Filed 10/10/1999
Board 01/15/2000
Assigned 10/12/1999

Review RAS
Date 10/18/1999

Agncy FIRE — FIRE: Fire Department
Div GENSAF — GENSAF: Public Safety - General Fund
Short Desc Fire truck hit volkswagen

Evaluation | Equipment | Keywords

New | Search | Print | Reports | Utility | Help | Close

99-C0001 | Arnold, Joseph | edit

Claim Search Criteria

Enter any criteria to filter and select desired Claim files.

Search Selection: Base | People

☑ Partial Match
File #

Status ++
Cat ++
Type ++
Attorney ++
Team ++
Staff ++
Juris
Cause ++
Track ++
Agncy ++
Div ++

Search words: + + +
or + + +

Found in: ☐ Title ☐ Status Desc ☐ Keyword ☐ Abstract Desc ☐ Disposition Notes ☐ Short Desc ☐ Location ☐ Location Code

Lookup Dates:	from	to
Open Dt	/ /	/ /
Incident	/ /	/ /
Filed	/ /	/ /
Board	/ /	/ /
Assigned	/ /	/ /
Review	/ /	/ /
Disposition	/ /	/ /

Search | Clear | Help | Saved | Cancel

Assignment Management

Assignment

Basic | Description | Status | Contacts | File Management

Title: Employee Use of Official Vehicles

File #: A99-00101
Staff: SAB
Team: ASGN

Category: OPN
Type: 220
Action: 004
Track: #
Priority: 1
Status: O

Received: 10/15/1999
Target: 11/14/1999
Complete: / /
Disposition:

Agncy: MAYOR — MAYOR: Mayor and City Council
Div: 011020 — 011020: General Fund

Desc: Opinion regarding the storage (garage) of County vehicles assigned to Department heads and use of vehicles for personnal errands to and from assigned work location.

New | Search | Print | Reports | Utility | Help | Close

A99-00101 | Employee Use of Official Vehicles | edit

Assignments Search Criteria

Enter any criteria to filter and search out desired Assignment files.

Search words:

or

or

Found in:
☑ Title ☑ Description ☐ Status Desc ☐ Disposition Notes ☐ Contact Name

Search type:
◉ Contains ○ Begins with

File #:
☑ Partial Match

Type ++
Track ++
Staff ++
Team ++

Status ++
Cat ++
Dispo ++

Agncy ...
Div ...

Lookup Dates: empty from to
Received Date ☐ / / / /
Target Date ☐ / / / /
Complete ☐ / / / /

Search
Clear
Cancel
Help

File Management

File Management

Basic | Description | Contents | Records Mgmt | Reserved

File # F00123 Title 123 Elm Place East

Opened 10/15/1999 Type REA Status O Source Operations

Subject REALEST Real Estate

Topic DEVEL Development

Category GEN General Files

Dept 1500 Acct 1001A01 Checked Out Date / /

Staff RMM Mobley, Richard M. Out Location

Team A General Advisory Services Review Date / /

Description Spell Check

123 ELM PLACE East
Review procurement process and potential negatives in City's procurement of this property especially liability for existing environmental hazards. Also determine necessary ADA retrofit liability.

New | Search | Print | Reports | Utility | Request | Help | Close

F00123 | 123 Elm Place East | edit

File Management

Basic | Description | Contents | Records Mgmt | Reserved

File Management Item — Add | Delete | Attach | Detach | Details

File #	Category	Date	Title
A99-00100	REA	1/1/1996	123 Elm Place East
L99-0035		7/12/1996	Halden, Harris vs. City of Metropolis
F00133	GEN	5/23/1994	Redevelopment Project 17 Area 52

Description

Lawsuit based on denial of building permit for 123 Elm Place.

New | Search | Print | Reports | Utility | Help | Close

F00123 | 123 Elm Place East | browse

CityLaw

Parties, Witnesses and Contacts

To add a Party to a file, retrieve the file using the Search button and click on the Parties Button, use the Tabs to go to the Parties, Witnesses or Contacts screen.

Then use the New button to add a person. On the Parties screen:

- The New button at the upper left is used to add a Primary Party.
- The New button at the upper right is used to add a Related Party. To add a Related Party, first enter and highlight the Primary Party to whom they are related, then highlight that person's name and use the new button at the upper right to enter their Attorney or other Related Party.

Notice that after clicking New your cursor will be flashing in the 'Search' field. All parties are saved to the database. Therefore, you may search for the person's name in the list by typing their last name in the Search field. The system will scroll through the alphabetical listing to the closest match.

If the person you are entering is already in the database, highlight their name in the list and click the Select button to add them to the file. You must then enter a Type code for the new Party.

If the person is not yet in the database, click the New button on the bottom of the dialog box. Then enter the persons name and click save.

The system will then display a blank form to enter details about that individual. Once this information is entered, it will be maintained in the database. Click the Save button again to add their information to the database.

Now with the person's name highlighted, click the Select button and they will be displayed as a party to the case. You must then enter a Type code.

To add or modify a person's address or other information, use the Edit button above their name. The Modify button on the Parties screen is used record their service information and any comments specific to this one case. Information entered from the Modify button will not be saved with their address in the people database, but only on this one case record.

CityLaw

Word Processing Documents

The Document option at the top center of the screen displays all documents that have been generated for the displayed record and is the means for adding new documents to the record.

'**Documents**' refers to any letters, pleadings, memos, transmittals or other written records that are created with your word processor.

Through Document Functions:

1. Data can be automatically extracted from the database and inserted into the appropriate place in a document.
2. Documents that you use from your own word processor can be created from a record.
3. The history of documents prepared for any particular record can be seen directly from **CityLaw**

To open a document first retrieve the appropriate file then go to the Documents button at the top center of the screen. Locate and highlight the document's Description. Use the Open button or double click on the Description to view, edit and/or print the document.

To create a new document for a file, retrieve the file, go to the Documents screen and click the New button. Then follow these steps:

1. Select from the list of displayed templates to generate a letter.
2. Enter an appropriate title that you want displayed in the document list after the document is attached to the record.
3. Change the Staff ID for this document, if appropriate.
4. Enter a summary of the document contents if it is not clear from the document title.
5. Indicate whether this document should be included on the File Index
6. Select OK.

Your word processor will open and with a new file based on the selected template.

When you are finished reviewing, editing or printing the document select close from the file menu and the system will return to the program.

WARNING: You must leave the name that CityLaw has assigned to the document. If you rename the document or save it to a different directory, CityLaw will not find it in the future.

CityLaw

Document Features

Use the Copy To button to copy a document to another case record. You may then retrieve that record and edit the title, summary and the document itself. The original document remains unchanged.

The File Index is a list of all documents associated with the case file. When a new document is entered on a case, you have the option to include it on the File Index. You can also add an item to the File Index for every other document in the case file. The File Index can be printed to have a numbered, sequential list of all documents in the case file.

Use the Import button to attach a document that you created directly from your word processor. After clicking the Import button, locate and select the file that you want to attach to the case. Then enter a title just as you would when attaching a new document. The original document remains unchanged and any future changes to the original document are not reflected in the imported copy of the document.

Use the Export button to copy a document to a diskette

System Management

Overview of System Management

- System Codes
- Options Menu
- Who Am I

System Codes

- Global
- File Management
- Litigation Case Management
- Assignment Management
- Liability Claims

Auto Numbering

Adding a New User

User Setup and Security

- Adding and Modifying User Ids
- Maintaining Profiles
- Maintaining Privileges
- Adding a New Profile
- Editing A Password

Overview of System Management

Access to System Management may be limited to designated staff members. If you do not see this icon on your CityLaw toolbar, your user id does not have access to System Management.

If you do have access to System Management, you can enter this function by clicking on the toolbar button or by selecting System Management from the Tools menu.

System Codes

Throughout the system, Codes are used to identify and label various records. Codes, such as those entered on the Basic Data screen represent significant information that allows for retrieval and statistical reporting.

Most Codes are maintained in Systems Management by Module. System-Wide Codes are maintained under Global System Management.

Options Menu

The Options Menu is used to access User Setup & Security and other maintenance utilities. The options to Upgrade, Reset Dialog Defaults and Rebuild Cache should only be used at the request of Cycom Data Systems, Inc. when program files are modified.

Who Am I

The Who Am I function on the Options Menu allows you to view the current User Id for CityLaw. This is the logged in user. The User Id determines which modules may be accessed from the computer, and the type of access available on that computer as specified in User Setup.

To view the User Id for a particular computer, select Who Am I from the Options menu. Enter the new User Id code, if appropriate and click OK.

The Team Id is used to indicate to which collection of staff members the user is assigned. Team may be used to give specific privileges to a group of staff members. It is also used to retrieve assignments or a staff calendar by a group of attorneys. This identification code is useful if an attorney's assigned team code is always entered on that attorney's records.

System Codes

Global System Management

The following System Codes are maintained from the Global Option of System Management.

Department and Account Codes with their Billing Information
Staff Types - Attorneys, Paralegals, Vendors, etc.
Teams
Prefix - Mr., Mrs. etc.
Calendar Types - Trial, Meeting, Board
Staff Codes - Attorneys, Investigators, Paralegals, Judges, Vendors, etc.
People - the People Database of contacts, plaintiffs, defendants, etc.
People Types
Consolidate People - Used when a person has been entered more than once in the Database.
Object Codes - Payment types
Street Types
Directions (Compass)

File Management

Litigation Case Management

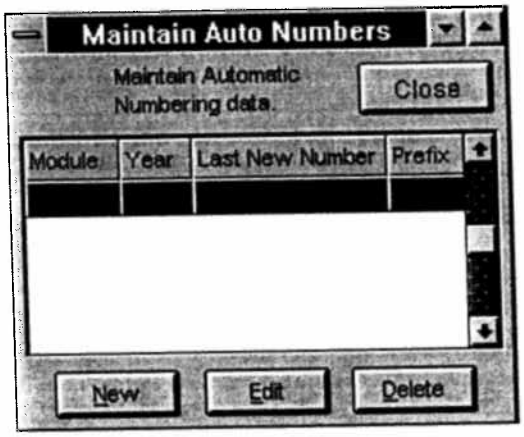
Assignment Management

Liability Claims Management

Auto Numbering

The last number that was used in auto-generating a file number for a record determines what the next number will be. The Auto Numbering maintenance function in System Management is used if it is necessary to change the auto numbering sequence.

For example, if the last number used to generate a File Management record was 97-1168 and the office wanted to reserve 10 records, that had not yet been entered into the system, for use on a specific matter, you would want to edit the 'Last New Number" to 97-1179 so that the next auto-generated number would be 97-1180.



Adding a New User

New Users are entered from the Global codes in System Management..

Select the staff type for the new user (Attorney, Investigator, Paralegal, etc.) and then click new. Enter the Code or User Id for the new user.

The Net User field allows users to open CityLaw without typing a User Id or Password. Enter the user's Network User Id in the Net User field to allow this type of access.

IMPORTANT : Use the Modules button while editing the User Id to indicate in which Modules the User Id should appear for entry on records. This establishes the codes that will appear on staff drop lists in each Module.

Access rights are defined in User Setup and Security. Checking a Module in System Management does <u>not</u> give a user access to that module.

User Setup and Security

User Setup and Security is used to establish and maintain the access and authority options for all system users.

It is accessed from the Options Menu. An administrative password is required.

The User Setup and Security window lists every User Id and Name with the Profile selected for that user. Use the drop list arrow to assign a Profile to an individual user. Use the Maintaining Profiles button to define the access options for each Profile as described below.

IMPORTANT: Click the Save button when exiting User Setup and Security to save any changes you have made.

Adding and Modifying User Ids

The User Id and Name of every user and staff member should be entered in System Management in the appropriate category (Attorney, Investigator, Paralegal, etc.).

The User Id is used for logging onto CityLaw/CountyLaw, for functions such as calendar items and time accounting, and for recording, tracking and searching staff codes on system files.

No two internal staff member User Ids may be the same, and no two external staff member User Ids may be the same. Internal staff members include all types except Judges, Vendors and Outside Counsel, which are considered external staff members.

Maintaining Profiles

Each user is assigned a Profile. The profile is defined by which modules may be accessed and by which Group of access options are available. The Groups are defined under Maintain Privileges.

For example, a Profile called 'Law Clerk' may have access to the modules Litigation and Time Accounting only. For Litigation they may only have General User and Reports access, and for Time Accounting they may only have General User access.

Therefore, any user with the Profile of 'Law Clerk' would have General User and Reports access to Litigation and only General User access to Time Accounting. In this example, 'General User' and 'Reports' are called Access Groups.

Maintaining Privileges

When a Profile is given access to a module one or more Access Groups may be selected to indicate the type of access allowed to that module. Each Group may be given access to either View or Modify specific information in each module.

Each Group is defined by its accessibility to Tabs (Description, Parties, Finance, etc) and buttons (New, Print, Reports, etc). If a Profile belongs to more than one Group, the access options for each of those Groups are available under that Profile, and the access available for one Group is not nullified by another Group.

In addition to the Groups that may be assigned to a Profile, access privileges should be setup up for the standard Groups including Team, Assigned Attorney, Staff Assigned, and Investigator Assigned. This defines the access that users will on records that are assigned to them.

Adding a New Profile

To add a new Profile, click the Add button on the Maintain Profiles window of User Setup and Security and type in the name of the Profile. Click OK.

Then with the new Profile highlighted click each module button and check the Access Groups if applicable. When you check the Access option for any module, the General User Group will be checked automatically since that is the minimum access any user will have. If any other access Group applies to the Profile, check that as well.

If a Profile belongs to more than one Group, the access options for each of those Groups are available under that Profile, and the access available for one Group is not nullified by another Group.

Editing A Password

On the User Setup and Security window highlight a User Id and Name, then click the Edit Password button to enter the password for each user. Click Save and the system will prompt for confirmation of the Password.

Once a Password is setup the user will logon to the CityLaw system with their User Id and Password unless their Network logon Id has been entered in System Management.

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INSTRUCTIONS FOR OPENING NEW LITIGATION MATTERS

1. SEARCH CITYLAW FIRST BY NAME AND DATE OF INCIDENT FOR ANY DUPLICATES

Check the Claims for any matters involving all parties to cross-reference. Reference these files in the reference section of Citylaw.

If there is a Notice file, pull the Notice File from the file cabinet, or Richie's or Dominic's Office. **Close it out on Citylaw. Change the reserve to zero.** Place Notice files in the Litigation File.

Click on litigation module

- Click new - Click auto
- This will assign it a number

Fill in the following information:

Title:	Name of Plaintiff v. New Haven, City of
File #:	Should automatically fill in
Attorney:	Leave Blank
Team:	L
Dept:	Name of Department - Zoning - Use "City Plan" Tax Appeals - Use "Board of Assessment Appeals"
Type:	Check dropdown list (D for Defense) (R for Respondent)
Category:	X= Taxes U= MVA I= Highway defect used for falls
Cause Code:	Taxes – Slip and Fall – City involved in an accident
Track:	N
Status:	Open and date
Cross Reference:	List all Notice File Numbers here and other litigation matters involved
Open Date:	The date file is opened
Incident Date:	Date of Incident
Filed Date:	(Civil) Return date (CHRO) Date filed in court. Federal matters will be 20 days from the date received by clerk's office
Date Served:	Date served to City Clerk
Date Assigned:	The Date Opened
Short Description:	MVA, Slip and fall, Uninsured Motorist Claim, etc.
Parties:	Fill in the name of all parties and their attorneys
File Management:	Type the first letter of the department and hit enter to get a list of departments

Foreclosure matters are assigned to Allison

Type Label (including Last Name, First Name and File Number).

Check to see if the file needs to be reported to the insurance carrier. If so, prepare letter with accord notice(s).

Prepare letter to Plaintiff's Counsel re: Medicare Reporting Requirements

Scan the Complaint to Nancy Pepe from the Copy Machine.

Give the File to Chris Neary to be assigned.

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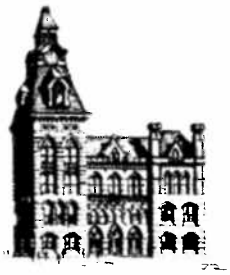
OFFICE OF THE CORPORATION COUNSEL

CASE DISPOSITION FORM



TO: Pamela Popolizio, Legal Assistant II

FROM:

SIGNED:

DATE:

1. Assigned Attorney:
2. Title of File:
3. CityLaw Office Number Assigned to Case:
4. Date of Disposition:
5. Type of Disposition _____ (See codes listed below)

If Judgment or Settlement: Amount $ _____

Check one: ***Collected*** by the city of New Haven _____

Paid by the city of New Haven _____

Date Check was Issued or Received:

Disposition Codes:

DIS - Dismissed
LOS - City Loss after hearing or trial
MOT - Dispositive Motion
N/A - Not Applicable: Worker's Compensation, Eminent Domain, Foreclosures & Bankruptcy
SET - Settlement
W/D - Withdrawal
WIN - City Win after hearing or trial

6. Closed File No._____

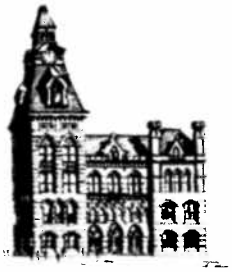
7. File Location: _____

NOTE:

a. Except Tax Appeals and cases with Post-Judgment Activity, all closed files shall be placed in the tan lateral cabinets in the file room in numerical order by Closed File Number.
b. All closed Tax Appeal files shall be sent directly to the Assessor's Office.
c. Any case with Post-Judgment Activity must note the file location on CityLaw.

OFFICE OF THE CORPORATION COUNSEL

CLAIM DISPOSITION FORM



TO: Pamela M. Popolizio, Paralegal

FROM:

SIGNED: _____

DATE:

1. Assigned Investigator:_____
2. Title of File:_____
3. CityLaw Office Number Assigned to Case:_____
4. Date of Disposition:_____
5. Type of Disposition:_____ (See below for Code numbers)

Disposition Codes:
- 5-Not Applicable
- C-Collected
- D-Denied
- L-Closed Litigated
- P-Paid
- R-Closed Referred to Other Agency
- S-Statute Expired-File Closed
- X-Cancelled

6. Status: Closed

7. File Location:_____

OFFICE OF THE CORPORATION COUNSEL

MEMORANDUM

TO:

FROM:

DATE:

ASSIGNMENT DISPOSITION FORM

1. Assigned Attorney: _____

2. Name of File: _____

3. Office No. of File: _____

4. Date of Disposition: _____

5. Type of Disposition: _____

   a. X Cancelled
   b. C Completed

6. Locator (Closed File No.): _____

7. File Location: _____ (See below for location name)

   Assessor's Office
   Jefferson Archives
   Other:_____

   Corporation Counsel Office
   Corporation Counsel Mail/Copy Room

8. Archive Date: _____

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CITY OF NEW HAVEN
PROPERTY DAMAGE CLAIMS INSTRUCTIONS

Pursuant to an order of the New Haven Board of Aldermen dated April 7, 1993, effective April 8, 1993 the Office of the Corporation Counsel has adopted the following claims instructions for property damage claims filed against the City of New Haven. Claims **must** be submitted to the City Clerk pursuant to these instructions. Thereafter, said claims will be forwarded to the Office of the Corporation Counsel for review, approval or denial.

1. Any claimant seeking to make a Property Damage Claim against the City of New Haven must submit the attached "Claims" Form to: Office of the City Clerk, 200 Orange Street, Rm 202, New Haven Connecticut 06510 as follows:

   a. within ninety (90) days from the date of the incident for claims alleging property damage resulting from a defective highway or sidewalk, and

   b. within six (6) months of the date of the incident for all other claims alleging property damage.

2. All claims forms must be fully completed, signed and notarized. Failure to do so may result in denial of your claim. If a particular question is inapplicable, claimant must indicate such inapplicability by placing "N/A" in the space provided.

3. All relevant estimates, receipts and insurance statements must be submitted with the claim form. Failure to do so may result in the denial of your claim. Claimants who dispose of the property or have repairs done, do so at their own risk.

4. Two (2) repair estimates and copies of any public record reports filed with relevant City department (such as police reports) are required for all property damage claims.

5. Claims alleging defective street conditions and claims alleging defective City sidewalks, sewers, trees, or facilities must be reported to the relevant City departments (e.g., Police, Public Works, Traffic, WPCA, Parks, etc) within twenty-four (24) hours of the incident. Failure to file such incident reports may result in the denial of your claim. Such reports shall include, but are not limited to, the exact date and approximate time of the incident, a detailed description of the

incident and the location, (e.g., street name and address, nearest intersecting street(s) and landmarks, if any).

6. All insurance payments for the incident must be reported promptly in writing to the Office of the Corporation Counsel. All such correspondence should reference claimant's name and the date of the incident. Claimant must attach a statement of applicable coverage for the damaged property from an insurance company. Additionally, claimant must attach a letter from the insurance carrier when said carrier denies coverage for the property damage which is the subject of this claim. If the damaged property damaged is not insured, claimants must so state in appropriate section of the Claim Form.

7. Claimants should pursue redress in other arenas for the following claims, as the Office of the Corporation Counsel **will not** review or approve the same through the procedures established herein:

a. **claims involving personal injury;**

b. claims for trash can damage, vehicle rentals, or damages or other losses resulting from vehicle tows;

c. claims due to a defect on a state highway or other property the maintenance of which, by law or contract, is not the City's responsibility;

d. claims involving Acts of God (hurricanes. tornadoes, blizzards, ice storms, etc.);

e. claims by City employees or Officials for losses at work, including but not limited to, personal property or cash lost, stolen, or damaged, except as specified under the appropriate collective bargaining agreement;

f. claims which are the subject of a Notice of intent to File a Lawsuit or an Administrative proceeding;

g. claims for damage done by mobs.

h. claims previously submitted and approved or denied by the Office of the Corporation Counsel;

i. claims for damage caused by sewer problems (must be forwarded directly to the Greater New Haven Water Pollution Control Authority);

j. claims involving property damage caused by the Fire Department acting pursuant to a valid and lawfully executed search warrant;

k. claims involving property damage caused by the Fire Department acting pursuant to its fire suppression, fire prevention and arson investigation functions;

8. Claimants may be required to agree to a visit by a City appraiser to determine actual monetary loss. The appraiser will report his/her findings to the Office of the Corporation Counsel. If a claimant refuses to permit said adjuster to assess property damage, the Office of the Corporation Counsel will deny the claim.

9. Address and telephone number changes must be reported promptly in writing to the Office of Corporation Counsel.

10. The Office of the Corporation Counsel will not process an approved claim for payment until the claimant completes and returns a form from releasing the City from any further liability for the same incident.

PLEASE KEEP THESE INSTRUCTIONS FOR YOUR INFORMATION
DO NOT SUBMIT WITH YOUR CLAIM

REV/JAN 2008

Claim No. C - 2011
#

CITY OF NEW HAVEN
PROPERTY DAMAGE CLAIM FORM

1. Name _____

2. Address _____
(street or post office box #) (city) (state) (zip code)

3. Telephone: day _____ eve _____

4. Check the type of claim:

Automobile Accident _____ Pothole/Manhole _____ Defective Sidewalk _____ Other _____

5. Below, explain the circumstances of the incident for which you are claiming property damage. Please include the date, the time, and the exact location of the alleged incident.

_____

_____

_____

_____

_____

6. What is the total amount of your claim against the City? $_____

7. Property damage estimate(s) or receipt(s) must be submitted with this form in order to process your claim. Attach estimate(s) or receipt(s) to this form. List the total of the estimate(s) or (receipt(s) and the name of the vendor. Indicate whether each amount listed relates to an estimate or receipt by circling the appropriate word below.

a. $_____ Vendor_____ ESTIMATE or RECEIPT

b. $_____ Vendor_____ ESTIMATE or RECEIPT

8. Is this the only claim you have ever submitted to the City? _____
If "no", list all other claims you have submitted, including for each claim the date of submittal, the type of claim, the amount of the claim, and the final disposition of the claim.

_____

_____

9. Do you have insurance on the damaged property? _____

a. If "yes", list the name, address, and telephone number of your insurance company and/or agent, and your insurance policy number. Attach a copy of the statements of applicable coverage for the damaged property.

_____

_____

b. Have you submitted a claim to your insurance carrier? _____ If "yes", when?_____

c. Does your insurance cover this claim? _____ If "no", attach a letter from your insurance carrier indicating the lack of coverage.

d. What is your deductible? $_____

e. Have you received any insurance payment for this incident? _____ If "yes", how much? $_____

f. Has any vendor received any insurance payment on your behalf for this incident?_____ If "yes", how much? $_____

10. List each City department or agency you reported this incident to, the date you reported it, and the name of the person you spoke to. Attach each incident report to this form.

Agency/Dept. _____ Date _____ Employee _____

Agency/Dept. _____ Date _____ Employee _____

I, the undersigned, do swear to the truthfulness and accuracy of the information above and that attached hereto in support of this claim against the City of New Haven for property damage. I understand that I have an obligation to inform the City of any insurance payments made to me or to any vendor on my behalf for this incident.

Claimant _____ Date _____
(signature)

_____
(printed name)

STATE OF CONNECTICUT:
ss:
COUNTY OF NEW HAVEN:

Personally appeared before me _____, this _____ day of _____, 20___, who subscribed the foregoing claim form and swore to the truth of the statements contained therein.

_____
Commissioner of the Superior Court, or Notary Public, or Justice of the Peace

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NOTICE OF CLAIM - INVESTIGATION CHECKLIST

Notice #: _____ Date of Incident: _____/_____/_____

Incident Location: _____

Date filed at City/Town Clerk's Office: ___/___/____ Reserve Amount: _____

Claimant's Name: _____ DOB: _____

Claimant's Address: _____

Description of Claim: _____

Information Obtained:

SPBI:_____ NHPD:_____ NHFD: _____ NHPW:_____

JUDICIAL INTERNET: ____ PARKS: _____ CIB: _____ CTDMV: _____

PHOTOS TAKEN: _____ TRAFFIC/PARKING: _____

Pertinent Information: _____

Comments: _____

Investigation completed: _____

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PMT/RB

CITY OF NEW HAVEN

DEPARTMENT OF FINANCE

Office of the Controller
200 Orange Street
NEW HAVEN, CONNECTICUT 06510
Tel. (203) 946-6700 - Fax. (203) 946-7244

JOHN DeSTEFANO, JR.
Mayor

Mark Pietrosimone
Controller

TO: Thomas Ude, Corporation Counsel

FROM: Mark Pietrosimone, Controller

DATE: July 2, 2004

RE: City Motor Vehicle Accident Reporting

The City's Motor Vehicle Accident Report form is being revised effective July 12, 2004. The new form limits the duplication of information, which is also contained on the Police motor vehicle accident report. (See attached). I have also attached the City Of New Haven Accident Procedure notice; a copy should be filled out and placed into each vehicle used by your department. These forms are also available on the N drive in the Risk Management folder.

The accurate reporting of all motor vehicle accidents involving City owned or other vehicles being used by employees in the performance of their job duties is vital to the City in order to address liability and insurance concerns.

We are still receiving city motor vehicle accident report packages that are incomplete, unsigned, on the wrong forms, do not include the police report, photographs or damage estimates. Additionally some motor vehicle accidents are not being reported at all. These are being brought to our attention by the filing of lawsuits against the City and also by CIRMA in regards to workers compensation subrogation.

If an employee is involved in a motor vehicle accident they are to immediately notify the Police and their supervisor. The supervisor is to immediately notify Corporation Counsel Chief Investigator Richard Bayer 946-6106 (Nextel 627-4780) or if not available Risk Management Program Coordinator Michael Barker 946-8299 (Nextel 627-4912).
In addition the department must submit the completed reporting package for all accidents to the Office of Corporation Counsel Chief Investigator within seven (7) days of the date of the accident. The package must include:

1. the Police report,
2. the Corporation Counsel Motor Vehicle Accident Report, signed/dated by the supervisor and employee (unless the employee was injured and it not available to sign the form),
3. the Department Head Motor Vehicle Accident Review, signed and dated,
4. the damage estimate, and
5. any photographs taken by the Department.

Incomplete motor vehicle accident reporting packages will be returned to the Department Head.
If you have any questions please call Mr. Richard Bayer at 946-6106 or Mr. Michael Barker at 946-8299.

cc: Derek Slap
Karen Dubois-Walton
Dr. R. Mayo
Henry Fernandez
Sheila Allen Bell
Michael Barker
Richard Bayer

CITY OF NEW HAVEN

Office of Corporation Counsel
165 Church Street
New Haven, Connecticut 06510
Telephone (203) 946-7958
Fax (203) 946-7942

MOTOR VEHICLE ACCIDENT REPORT

INSURANCE INFORMATION:
Company:
Insurance Co. of the State of Pennsylvania
Policy Number: 41034917
Effective Date : 8/12/03

Reporting Check List						If any employee was injured		
	☐ Accident notification call to Corp Counsel	☐ Police Report Attached	☐ Photos Attached ☐ No Photos Taken	☐ Damage Estimate attached ☐ No Damage	☐ Submitted for Dept. Head Review		☐ CIRMA notified. 1-800-652-4762	☐ Supervisor Incident Investigation Form submitted to Risk Management

REPORT & ATTACHMENTS MUST BE SUBMITTED TO: CORPORATION COUNSEL CHIEF INVESTIGATOR. WITHIN 7 DAYS

(Please Print)

DEPARTMENT: _____ **DATE / TIME OF ACCIDENT:** _____ _____ **A.M. P.M.**

NAME OF EMPLOYEE: _____ **SSN/EMPLOYEE #** _____ **TELEPHONE #:** _____

LOCATION OF ACCIDENT: _____

EXPLAIN HOW ACCIDENT OCCURRED: _____

DESCRIBE ANY PROPERTY DAMAGE (OTHER THAN AUTO): _____

NAMES, ADDRESSES & TELEPHONE #S OF WITNESSES: _____

COMPLETE THIS SECTION <u>ONLY IF POLICE REPORT IS NOT ATTACHED</u>:

EMPLOYEE DATE OF BIRTH: ____/____/____ **OPERATOR LICENSE #:** _____ **STATE:** _____

POLICE COMPLAINT #: _____ **ENFORCEMENT ACTION TAKEN:** ☐ **YES** ☐ **NO** **STATUTE #:** _____

REGISTRATION #: _____ **STATE:** ____ **VEHICLE YEAR, MAKE & MODEL:** _____

VEHICLE ID #: _____ **VEHICLE TOWED:** ☐ **YES** ☐ **NO LOCATION OF VEHICLE** _____

INJURIES: ☐ **YES** ☐ **NO IF YES EXPLAIN:** _____

DAMAGE TO CITY VEHICLE: _____

<u>INFORMATION REGARDING 2ND VEHICLE, IF ANY:</u>

OPERATOR'S NAME: _____ **DATE OF BIRTH:** ____/____/____

ADDRESS: _____ **CITY/TOWN** _____ **STATE** _____ **TELE #** _____

OPERATOR'S LICENSE #: _____ **STATE:** _____ **REGISTRATION #** _____ **STATE** _____

VEHICLE YEAR, MAKE & MODEL: _____ **VEHICLE ID #:** _____

INSURANCE CARRIER'S NAME & ADDRESS: _____

POLICY #: _____ **TELEPHONE #:** (____) _____

INJURIES: ☐ **YES** ☐ **NO IF YES EXPLAIN:** _____

DAMAGE TO VEHICLE: _____

VEHICLE TOWED: ☐ **YES** ☐ **NO** **ENFORCEMENT ACTION TAKEN:** ☐ **YES** ☐ **NO** **STATUTE #:** _____

EMPLOYEE'S SIGNATURE: _____ **DATE/TIME:** _____ **A.M. P.M.**

SUPERVISOR'S SIGNATURE: _____ **DATE/TIME:** _____ **A.M. P.M.**

CITY OF NEW HAVEN
Thomas W. Ude, Jr. Corporation Counsel
Richard Bayer, Chief Investigator
165 Church Street
New Haven, Connecticut 06510
Telephone (203) 946-6106
Fax (203) 946-7942

Company:
Insurance Co. of the State of Pennsylvania
Policy Number:
41034917
Effective Date:
8/12/03

DEPARTMENT HEAD MOTOR VEHICLE ACCIDENT REVIEW

Department:_____ **Date of Accident:** _____

Employee involved:
Name: _____ **Employee #** _____
Job Title: _____

Was employee disciplined: ☐ **Yes** ☐ **No**
Explain_____

_____

_____

_____

_____

Department Head Signature: _____
Date: _____

CITY OF NEW HAVEN
ACCIDENT PROCEDURE
(DO NOT REMOVE FROM VEHICLE)

In the event **of any accident** involving a City owned, leased, or over the road equipment/vehicle you must adhere to the following procedures:

- **DO NOT LEAVE THE SCENE OF THE ACCIDENT.** (If another vehicle is involved in the crash or witnessed the crash and is leaving the scene record the license plate number.)
- **IMMEDIATELY**, notify the local police.
- **IMMEDIATELY**, notify the driver's immediate supervisor.
- **IMMEDIATELY**, after arriving at the accident scene the driver's supervisor is to notify the Corporation Counsel Chief Investigator Richard Bayer 627-4780, or if not available, Risk Management Program Coordinator Michael Barker 627-4912.
- The driver's supervisor is to notify their Department Head as per their Department procedures.
- If any employee(s) are injured: During normal working hours employee(s) with non-life threatening injuries should go to St. Raphael's Occupational Health, 175 Sherman Avenue for treatment. Life threatening or serious injuries should be treated at the nearest hospital emergency room. The supervisor is to notify CIRMA of a first report of injury in accordance with their Department procedure (1-800-652-4762).
- As soon as possible, the supervisor and employee(s) are to complete a City Motor Vehicle Accident Report, and if employee injuries are involved a Supervisor's Incident Investigation Form.
- . Both forms are to be forwarded to their Department Head immediately.

City Vehicle Information:

Year:_____

Make:_____

Model:_____

License Plate:_____

V.I.N.:_____

City Vehicle Insurance Information:

Insurance Co. of the State of Pennsylvania (A.I.G.)
Policy # 41034917

Agent: Marshall & Sterling

Claims forms for other parties are available from the City Clerk's Office. Completed forms are to be submitted to the City Clerk's office.

KLEER-FAX
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Request To Open Assignment File

	Title			
2.	Date of Request		CC No	
3.	Date Rec'd by CC		Attorney	
4.	Department			
5.	City Contact			
6.	Due Date			
7.	Priority	High	Normal	Low
8.	Assignment	Please indicate (see lists below) Category Code	Type Code	
9.	Purpose			

CATEGORY CODE:

ACQ	Acquisition	FOI	Freedom of Information	PRJ	Project
AGR	Agreements	LEG	Legislation	REL	Release/Waiver
AGX	Agreements, Complex	LEN	Liens	RSH	Research
APP	Application	LNS	Loans	RES	Resolutions
DEF	Assessment Deferral	OFC	Office Administration (Internal)	TAX	Tax
DIS	Disposition	OPN	Opinions and Advice		

TYPE CODE:

ADMN	Office Administration	HLD	Hold Harmless
AFF	Affidavit	HSG	Housing Code
AG01	Agreement, Exempt Professional	INV	Investigation
AG02	Agreement, Formal Bid	LGPJ	Large Project
AG03	Agreement, CDBG 3rd Party	LICS	Licenses
AG04	Agreement, Legal Services	LNDA	Land Disposition Agreement
AG05	Agreement, RFP	LOAG	Loans
AG06	Agreement, Non-CDBG 3rd Party	LOAN	Mortgage
AG07	Agreement, Complex	LOAV	Legal Advice-Verbal
AG08	Agreement, Complex (Façade)	LOPS	Legal Opinions
AG09	Agreement, Sole Source	LRSH	Legal Research
AG10	Agreement, Security	LSES	Leases
AG11	Agreement, Revenue	MOD	Modification
AG12	Agreement, Revenue	MOU	Memorandum of Understanding
APP	Applications	ORD	Ordinance
ASB	Asbestos	PCHS	Purchase Real Estate
ADCM	Board or Commission, Meeting/Advice	POA	Power of Attorney
BKCY	Bankruptcy	REGS	Regulations
BLDG	Building Code	REL	Release
BND	Bond	RELO	Relocation
CEOC	Certificate of Completion	RESD	Residential
[illegible]O	Demolition	SUB	Subordination of Mortgage
[illegible]ND	Eminent Domain	TRAP	Transfer/Assignment of Property
ESMN	Easements	TS	Title Search
EST	Estates	TX01	Tax, Abatement
FOI	Freedom of Information	TX02	Tax, Assessment Deferral
GR01	Grant, Federal	TX03	Tax, Deed in Lieu of
GR01	Grant, Federal	TX04	Tax
GR03	Grant, Other		

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M

LCI ADMINISTRATIVE SERVICES Transmittal to OFFICE OF THE CORPORATION COUNSEL		File No:
RESIDENTIAL LOAN CLOSINGS	CHECKLIST re:	Contents of file to be forwarded to LCI Legal by LCI Staff.

Name(s) of Borrower(s):

Property Address:

PROGRAM/LOAN FILE ITEM DESCRIPTION	LCI YES	NO	N/A	LEGAL COMMENTS
Note and Deed Information Sheet w/certification and sign-offs (ORIGINAL)				
Administrative Services Checklist w/ certification and sign-off (Copy)				
CAPO form (issued by Finance) (ORIGINAL)				
Loan Advisory Committee Report (ORIGINAL)				
GNHCLF Program Checklist w/certification and sign-off (Copy)				
LCI Loan Review Report - by GNHCLF (Copy)				
Non-Collusion Affidavit (Revised) (ORIGINAL)				
Disclosure (Revised) w/ Tax Stamp (ORIGINAL)				
LCI Loan Application (Copy)				
Environmental Review Record (Copy)				
Certification of Developer's Costs (UDAG) (Copy)				
Borrower's Certification re Occupancy (Copy)				
Seller's Ownership/Title Deed (Copy)				
Final Inspection Report (Paint/Rehab) (Copy)				
Certificate of Use and Occupancy (UDAG) (Copy)				
Real Estate Sales Agreement (Copy)				
Commitment Letter from 1st Mortgagee (Copy)				
Work/Bid Estimate (Paint/Lead/Rehab) (Copy)				
Homeowners Certificate of Completion (Copy)				

I certify delivery of the above file to Corporation Counsel and confirm that all necessary documents as indicated above have been forwarded.

Date: _____ Signed: _____

Print Name & Title:

Corporation Counsel File Number: _____

Assigned to: Attorney _____

Paralegal _____

LCI LEGAL: LOAN PROCESSING CHECKLIST

DOCUMENT REVIEW:

_____ Documents Drafted (Note, Mortgage, Agreement, Truth in Lending) to Attorney _____

_____ Documents reviewed by Attorney and returned to Paralegal _____

_____ File Complete and Ready to Close: _____

Draft of Loan Documents forwarded to Borrower(s) / Attorney _____ (Date)

PRE-CLOSING:

_____ Copy of Deed without / with HOME / UDAG Restrictions

_____ Copy of Mortgage Title Insurance Policy

_____ Copy of HUD (confirm downpayment $_____)

_____ Copy of Homeowners Insurance w/ City as Additional Insured

CLOSING:

_____ Fully executed copy of Transfer Deed

_____ Executed copy of HUD

_____ Copy of First Mortgage Doc's

_____ Original Mortgage Title Insurance Policy for City

_____ Copy of Picture ID

_____ Keep the following original City Loan Doc's: Cmmt, Note and Truth in Lending

POST CLOSING:

____ Copy of Loan Documents to Finance and Administrative Services

____ Complete Title Policy w/ Recording Times

____ Close out Citylaw

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LITIGATION SETTLEMENT COMMITTEE CHECKLIST

- Schedule of Meetings-Wednesdays @ 5:30 p.m. in conference room of Corporation Counsel's office
- Quorum-4 members is required for meeting to take place
- Litigation Paralegal covers meeting and is keeper of tape recorder
- See directory u:admin\lsc
- Memo to attorneys (including Dan Roche) u:admin\lsc\atty.mem
- Notify members w/memo u: admin\lsc.mem
- Memo to Town Clerk u: admin\lsc\rogers.ltr (send w/in 24 hours of meeting or meeting can't take place
- Call all members re Quorum u:admin\lsc\quorum.frm
- Call all members re Confirmation day before
- Cancellation Notice to Town Clerk u:admin\lsc\sccance.not
- See mail merge for envelopes to members u:admin\lsc\envel.mrg
- See reg. envelopes to members u:admin\lsc\certif.mal
- Minutes-stop tape recorder during executive session
- Approvals-All Recommendations to Compromise (RTC) that are passed must be signed by Corporation Counsel
- Send RTC to Mayor w/settlement slip for signature
- Prepare voucher for AP upon receipt w/settlement amount-Ask AP to Hold Check for Corporation Counsel
- Obtain Withdrawal & Release from assigned attorney prior to releasing check
- Send letter certified w/check to opposing counsel u:admin\fofrms\attysettfrm

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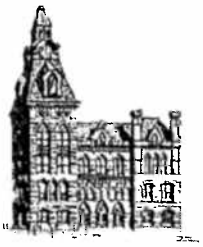
OFFICE OF THE CORPORATION COUNSEL



MEMORANDUM

To: All Coordinators and Department Heads

CC: Sean Matteson, Chief of Staff
Jessica Mayorga, Public Information Officer

From: Victor A. Bolden, Corporation Counsel VB

Date: August 19, 2010

Re: Connecticut Freedom of Information Act

As you are aware, there is an extensive body of law regarding the retention and disclosure of public records as required by the Connecticut Freedom of Information Act ("FOIA"), and the Office of the Corporation Counsel is available to assist you and your employees with compliance.

The "keepers" of public records are legally responsible for acknowledging receipt of requests and for assembling responsive records. Statutory compliance is more effective and efficient, if each department has a person (or two) identified as its FOIA contact. These contacts should be responsible for day-to-day FOIA activities within each department.

In order that this office may assist you with your legal obligations as the "keepers" of various public records, I am asking you to do the following by Friday, **September 10th**:

1. For department heads, please provide the name of a departmental FOIA contact person or persons. If your department does not have a FOIA contact person, please appoint someone.

2. For coordinators, please provide the name of a FOIA contact person responsible for the inter-departmental coordination within their reports that is sometimes required.

3. For department heads and coordinators, please advise all employees that every request for records maintained or kept on file in your department should be directed to the designated FOIA contact person(s).

On an ongoing and as needed basis, this office will be providing training and support for all City FOIA contacts, particularly in the case of atypical requests or requests that present legal issues or questions.

If you have any questions or concerns, please contact either Assistant Corporation Counsel Kathleen Foster at x7971 or me at x7951.

Thank you for your attention to this matter.

Malinda F for Eng

City of New Haven FOIA Contact Person List - FY 2011

Department	Contact Person	Phone	Fax
Coordinators			
Chief Administrative Officer	Jennifer Pugh/Robert Smuts	7900	7911
Chief of Staff	Che Dawson	7670	5704
Community Services Administration			
Controller			
Corporation Counsel	Kathleen Foster	7971	7942
Economic Development	Michael Pinto	7810	7808
Management & Budget			
Department Heads			
Assessor			
Building Department	Andrew J. Rizzo, Jr.	8046	8049
City Plan			
City Clerk			
CEO			
Cultural Affairs & Market NH	Barbara Lamb	8378	7808
Disabilities Services	Michelle Duprey	7651	
Education, Board of			
Elderly Services			
Engineering			
Fair Rent	Otis Johnson	8157	8587
Fire			
Health			
Human Resources			
Legislative Services	Albert Lucas	8371	7476
Library			
Livable Cities Initiative			
Parks	Lynn Piekarz	6761	8024
Personnel			
Police			
Public Works			
Purchasing	Michael Fumiatti	8207	8206
Registrar of Voters-Dem.			
Registrar of Voters-Rep.			
Transportation, Traffice & Parking			
Youth			
Division Directors			
Accounts Payable			
Affirmative Action			
Child Development			
Civil Service			
Communications			
Information Technology			
Labor Relations	Joanne Courtmanche	7153	7924
Medical Benefits			
New Haven Residents			
Payroll & Pension			
Special Funds Accounts			
Tax Office			
Department	Contact Person	Phone	Fax

As of 7/1/2010

City of New Haven FOIA Contact Person List - FY 2011

Treasurer			
Vital Statistics			
Weights & Measures			
Worker's Compensation			

As of 7/1/2010

Guide to Connecticut Open Meetings Laws for Members of City Boards and Commissions

1. General:

The meetings, hearings and other proceedings of your board or commission must be made open to the public.

All business to be considered or acted upon by your board or commission involving a matter over which it has authority must be done in an open meeting, with some specific exceptions, including the following: meetings of certain personnel search committees; collective bargaining strategy and negotiating sessions; caucuses; chance or social gatherings not intended to relate to official business.

The following rules govern meetings, and any violations may result in the Connecticut Freedom of Information Commission nullifying actions taken in meetings at which a violation occurs. The chair of your board or commission is responsible for ensuring compliance with these rules.

2. Public and Press Access:

Members of the public may attend open meetings of your board or commission. **No registration or other requirements may be imposed** on a member of the public seeking attendance at a public meeting.

Members of the public may also participate in open meetings telephonically, using the speaker phone feature so that they may be heard by those in attendance.

Connecticut state statute does not require that the public be allowed to speak at open meetings, only that they be allowed to attend as observers. Speaking privileges are determined either by other laws, such as a statute requiring a public hearing, or according to procedures adopted by your board or commission.

The public, as well as the news media, may photograph, record or broadcast meetings, subject to prior reasonable rules regarding non-interference with the conduct of the meeting.

3. Types of meetings:

Regular meetings: Your board or commission must annually file a schedule of regular meetings with the town clerk. Your board or commission must provide the place designated for these meetings to the public. If a regular meeting falls on a holiday, it must be held on the next business day.

Special meetings: Special meetings may be called up to 24 hours before the time set for the meeting. Your board or commission must file a notice stating the time, place, and business of the meeting with the town clerk. All rescheduled regular meetings are treated as special meetings.

Any regular or special meeting may be adjourned to a time and place specified by the order of adjournment. A copy of the order of adjournment must be prominently and visibly placed on the door of the place at which the meeting was scheduled to be held within 24 hours of the adjournment. If the order fails to specify the time, it shall be held at the time specified for regular meetings. Any meeting or hearing may be continued or recontinued to a subsequent meeting in the same manner as adjournment.

4. **Executive Sessions:**

Your board or commission may vote to close portions of meetings to the public only if a **2/3 majority vote in public session to do so**.

Executive sessions can only be used to discuss the following matters: specific employees (unless the employee concerned requests that the discussions be open to the public); strategy and negotiations regarding pending claims and litigation; security matters; real estate acquisition (if openness might increase price); or any matter that would result in the disclosure of a public record exempted from the disclosure requirements for public records (see Section 1-210 of the statute).

Non-members may be invited to present testimony or opinion in the executive session, but their attendance must be **limited to the time necessary for that function**.

The minutes of a meeting at which an executive session occurs must note the names of all who were in attendance at the closed session, except job applicants who were interviewed.

5. **Agendas and minutes:**

Agendas must list all issues your board or commission will vote on, and must be made available at least **24 hours** before meetings. For regular meetings, business not included on agendas can be added to it **only if a 2/3 majority** vote to do so. Items may **never** be added to the agenda of a special meeting. **Action must never be taken on any items not included on the agenda.**

Minutes of each meeting must be made available within **seven days** in the office of your board or commission, or in the office of the town clerk. For special meetings, this excludes holidays and weekends.

Minutes must record the **attendance** of members, a record of **all votes** taken place, and a record of **each member's vote** on every issue on the agenda.

Agendas and minutes must be made available on the City's website as soon as possible.

All documents and memoranda that are distributed among members of your board or commission **during an open meeting are considered public records**. In order to discuss

documents that would be exempted under Section 1-210 of the statute, your board or commission must vote to enter an executive session.

Your board or commission must send a notice of its meetings at least one week prior to the meeting to anyone who has requested it. Your board or commission may charge a reasonable fee for this service.

6. Voting

Your board or commission **must take up or down votes on every issue on the agenda**. It may not simply operate by informal consensus. The outcome of each vote and the votes of each member must be recorded in the minutes of each meeting and made available on the City's website within **48 hours**, excluding weekends and holidays.

Under the New Haven Code of Ethics, no member may vote on any issue in which he or she or a family member has a personal interest.

NOTICE OF MEETINGS

Type	Notice	Agenda/ Notice Contents	Adding to Agenda/ Notice	Filing Record of Votes	Filing Minutes
Regular	File yearly schedule with Sec'y Of State (state) or Town Clerk (municipal) by Jan. 31st.**	Agenda available at least 24hrs. before meeting.**	Agenda items may be added by 2/3 vote of those members present and voting.	Within 48 hrs. after meeting (if minutes not available within 48 hours).	Within 7 calendar days after meeting.***
Special	At least 24 hrs. before meeting, file at Sec'y Of State (state) or Town Clerk (municipal).*	At least 24 hrs. before meeting. Time, place and business must be included in notice.*	Not permitted	Within 48 hrs. after meeting (if minutes not available within 48 hours).	Within 7 business days after meeting.***
Emergency	None required if emergency is justified.	None required if emergency is justified.	Only emergency matters may be considered.	Within 48 hrs. after meeting (if minutes not available within 48 hours).	Within 72 hrs. after meeting. Must state reason for emergency.***

* Available with Sec'y Of State (state) or Town Clerk and in place of business. Also, must be posted on agency website.
** Available with Sec'y Of State (state) or Town Clerk and in place of business. Also, must be posted on websites for state agencies only.
***Must be posted on agency website for state agencies only.

THE CONNECTICUT FREEDOM OF INFORMATION ACT AS CODIFIED IN CHAPTER 14 OF CONNECTICUT GENERAL STATUTES (INCLUDING 2009 AMENDMENTS)*

Sec. 1-200. (Formerly Sec. 1-18a). Definitions. As used in this chapter, the following words and phrases shall have the following meanings, except where such terms are used in a context which clearly indicates the contrary:

(1) "Public agency" or "agency" means: (A) Any executive, administrative or legislative office of the state or any political subdivision of the state and any state or town agency, any department, institution, bureau, board, commission, authority or official of the state or of any city, town, borough, municipal corporation, school district, regional district or other district or other political subdivision of the state, including any committee of, or created by, any such office, subdivision, agency, department, institution, bureau, board, commission, authority or official, and also includes any judicial office, official, or body or committee thereof but only with respect to its or their administrative functions; (B) Any person to the extent such person is deemed to be the functional equivalent of a public agency pursuant to law; or (C) Any "implementing agency", as defined in section 32-222.

(2) "Meeting" means any hearing or other proceeding of a public agency, any convening or assembly of a quorum of a multimember public agency, and any communication by or to a quorum of a multimember public agency, whether in person or by means of electronic equipment, to discuss or act upon a matter over which the public agency has supervision, control, jurisdiction or advisory power. "Meeting" does not include: Any meeting of a personnel search committee for executive level employment candidates; any chance meeting, or a social meeting neither planned nor intended for the purpose of discussing matters relating to official business; strategy or negotiations with respect to collective bargaining; a caucus of members of a single political party notwithstanding that such members also constitute a quorum of a public agency; an administrative or staff meeting of a single-member public agency; and communication limited to notice of meetings of any public agency or the agendas thereof. A quorum of the members of a public agency who are present at any event which has been noticed and conducted as a meeting of another public agency under the provisions of the Freedom of Information Act shall not be deemed to be holding a meeting of the public agency of which they are members as a result of their presence at such event.

***NOTE:** This compilation of the Freedom of Information Act is unofficial and for the convenience of the public only. While every effort was made to attain complete accuracy herein, the reader is advised to consult the Connecticut General Statutes for the official codification of the law.

(8) "Pending claim" means a written notice to an agency which sets forth a demand for legal relief or which asserts a legal right stating the intention to institute an action in an appropriate forum if such relief or right is not granted.

(9) "Pending litigation" means (A) a written notice to an agency which sets forth a demand for legal relief or which asserts a legal right stating the intention to institute an action before a court if such relief or right is not granted by the agency; (B) the service of a complaint against an agency returnable to a court which seeks to enforce or implement legal relief or a legal right; or (C) the agency's consideration of action to enforce or implement legal relief or a legal right.

(10) "Freedom of Information Act" means this chapter.

(11) "Governmental function" means the administration or management of a program of a public agency, which program has been authorized by law to be administered or managed by a person, where (A) the person receives funding from the public agency for administering or managing the program, (B) the public agency is involved in or regulates to a significant extent such person's administration or management of the program, whether or not such involvement or regulation is direct, pervasive, continuous or day-to-day, and (C) the person participates in the formulation of governmental policies or decisions in connection with the administration or management of the program and such policies or decisions bind the public agency. "Governmental function" shall not include the mere provision of goods or services to a public agency without the delegated responsibility to administer or manage a program of a public agency. (P.A. 75-342, §1; P.A. 77-421; P.A. 77-609, §1; P.A. 83-67, §1; P.A. 83-372; P.A. 84-546, §3; P.A. 87-568, §1; P.A. 90-307, §2; P.A. 91-140, §1; P.A. 93-195, §1; P.A. 95-79, §2; P.A. 97-47, §1; P.A. 00-136, §1; P.A. 01-169, §1; P.A. 02-130, §17.)

Sec. 1-201. (Formerly Sec. 1-19c). Division of Criminal Justice deemed not to be public agency, when. For the purposes of subdivision (1) of section 1-200, the Division of Criminal Justice shall not be deemed to be a public agency except in respect to its administrative functions. (P.A. 84-406, §12; P.A. 00-66, §4.)

Sec. 1-202. (Formerly Sec. 1-20e). Application of freedom of information provisions to agency committee composed entirely of individuals who are not members of the agency. Any public agency may petition the Freedom of Information Commission before establishing a committee of the public agency which is to be composed entirely of individuals who are not members of the agency, to determine whether such committee may be exempted from the application of any provision of the Freedom of Information Act. If the commission, in its judgment, finds by reliable, probative and substantial evidence that the public interest in exempting the committee from the application of any such provision clearly outweighs the public interest in applying the provision to the committee, the commission shall issue an order, on appropriate terms, exempting the committee from the application of the provision. (P.A. 93-195, §2; P.A. 97-47, §7.)

Secs. 1-203 and 1-204. Reserved for future use.

information between the commission and such municipality. The commission may amend the model ordinance from time to time.

(g) When the General Assembly is in session, the Governor shall have the authority to fill any vacancy on the commission, with the advice and consent of either house of the General Assembly. When the General Assembly is not in session any vacancy shall be filled pursuant to the provisions of section 4-19. A vacancy in the commission shall not impair the right of the remaining members to exercise all the powers of the commission and three members of the commission shall constitute a quorum.

(h) The commission shall, subject to the provisions of chapter 67, employ such employees as may be necessary to carry out the provisions of this chapter. The commission may enter into such contractual agreements as may be necessary for the discharge of its duties, within the limits of its appropriated funds and in accordance with established procedures.

(i) The Freedom of Information Commission shall not be construed to be a commission or board within the meaning of section 4-9a. (P.A. 75-342, §15; P.A. 77-609, §7; P.A. 77-614, §73; P.A. 78-280, §8; P.A. 78-315, §3; P.A. 79-560, §1; P.A. 79-575, §1; P.A. 86-390, §§1, 2; P.A. 87-496, §5; P.A. 88-230, §1; P.A. 89-251, §57; P.A. 90-98, §1; P.A. 91-347, §3; P.A. 93-142, §§4, 7; P.A. 95-220, §§4-6; P.A. 97-47, §13; June 18 Sp. Sess. P.A. 97-9, §§27, 50; P.A. 00-136, §§8, 10; P.A. 06-187, §69; P.A. 07-202, §13.)

Sec. 1-205a. Recommended appropriations. Allotments. (a) Notwithstanding any provision of the general statutes, the appropriations recommended for the Freedom of Information Commission, as established in section 1-205, shall be the estimates of expenditure requirements transmitted to the Secretary of the Office of Policy and Management by the executive director of the commission and the recommended adjustments and revisions of such estimates shall be the recommended adjustments and revisions, if any, transmitted by said executive director to the Office of Policy and Management.

(b) Notwithstanding any provision of the general statutes, the Governor shall not reduce allotment requisitions or allotments in force concerning the Freedom of Information Commission. (P.A. 04-204, §11.)

Sec. 1-206. (Formerly Sec. 1-21i). Denial of access to public records or meetings. Appeals. Notice. Orders. Civil penalty. Service of process upon commission. Frivolous appeals. (a) Any denial of the right to inspect or copy records provided for under section 1-210 shall be made to the person requesting such right by the public agency official who has custody or control of the public record, in writing, within four business days of such request, except when the request is determined to be subject to subsections (b) and (c) of section 1-214, in which case such denial shall be made, in writing, within ten business days of such request. Failure to comply with a request to so inspect or copy such public record within the applicable number of business days shall be deemed to be a denial.

Freedom of Information Act. The commission may declare null and void any action taken at any meeting which a person was denied the right to attend and may require the production or copying of any public record. In addition, upon the finding that a denial of any right created by the Freedom of Information Act was without reasonable grounds and after the custodian or other official directly responsible for the denial has been given an opportunity to be heard at a hearing conducted in accordance with sections 4-176e to 4-184, inclusive, the commission may, in its discretion, impose against the custodian or other official a civil penalty of not less than twenty dollars nor more than one thousand dollars. If the commission finds that a person has taken an appeal under this subsection frivolously, without reasonable grounds and solely for the purpose of harassing the agency from which the appeal has been taken, after such person has been given an opportunity to be heard at a hearing conducted in accordance with sections 4-176e to 4-184, inclusive, the commission may, in its discretion, impose against that person a civil penalty of not less than twenty dollars nor more than one thousand dollars. The commission shall notify a person of a penalty levied against him pursuant to this subsection by written notice sent by certified or registered mail. If a person fails to pay the penalty within thirty days of receiving such notice, the superior court for the judicial district of Hartford shall, on application of the commission, issue an order requiring the person to pay the penalty imposed. If the executive director of the commission has reason to believe an appeal under subdivision (1) of this subsection or subsection (c) of this section (A) presents a claim beyond the commission's jurisdiction; (B) would perpetrate an injustice; or (C) would constitute an abuse of the commission's administrative process, the executive director shall not schedule the appeal for hearing without first seeking and obtaining leave of the commission. The commission shall provide due notice to the parties and review affidavits and written argument that the parties may submit and grant or deny such leave summarily at its next regular meeting. The commission shall grant such leave unless it finds that the appeal: (i) Does not present a claim within the commission's jurisdiction; (ii) would perpetrate an injustice; or (iii) would constitute an abuse of the commission's administrative process. Any party aggrieved by the commission's denial of such leave may apply to the superior court for the judicial district of Hartford, within fifteen days of the commission meeting at which such leave was denied, for an order requiring the commission to hear such appeal.

(3) In making the findings and determination under subdivision (2) of this subsection the commission shall consider the nature of any injustice or abuse of administrative process, including but not limited to: (A) The nature, content, language or subject matter of the request or the appeal; (B) the nature, content, language or subject matter of prior or contemporaneous requests or appeals by the person making the request or taking the appeal; and (C) the nature, content, language or subject matter of other verbal and written communications to any agency or any official of any agency from the person making the request or taking the appeal.

(4) Notwithstanding any provision of this subsection to the contrary, in the case of an appeal to the commission of a denial by a public agency, the commission may, upon motion of such agency, confirm the action of the agency and dismiss the appeal without a hearing if it finds, after examining the notice of appeal and construing all allegations most favorably to the appellant, that (A) the agency has not violated the Freedom of Information Act, or (B) the agency has committed a technical violation of the Freedom of

may, in addition to any other powers conferred by law, order the disclosure of any such records withheld in violation of the Freedom of Information Act and may assess against the state reasonable attorney's fees and other litigation costs reasonably incurred in an appeal in which the complainant has prevailed against the Department of Environmental Protection. (P.A. 75-342, §14; P.A. 76-435, §25; P.A. 77-403; P.A. 77-603, §2; P.A. 77-609, §6; P.A. 78-331, §57; P.A. 81-431, §2; P.A. 83-129, §1; P.A. 83-587, §69; June Sp. Sess. P.A. 83-31, §1; P.A. 84-112, §2; P.A. 84-136; P.A. 84-311, §1; P.A. 86-408, §1; P.A. 87-285, §2; P.A. 87-526, §4; P.A. 88-230, §1; P.A. 88-317, §39; P.A. 88-353, §2; P.A. 90-98, §1; P.A. 90-307, §1; P.A. 92-207, §2; P.A. 93-142, §§4, 7; P.A. 93-191, §1; P.A. 95-220, §§4-6; P.A. 97-47, §§10-12; P.A. 00-136, §6; P.A. 07-202, §11.)

Secs. 1-207 to 1-209. Reserved for future use.

Sec. 1-210. (Formerly Sec. 1-19). Access to public records. Exempt records. (a) Except as otherwise provided by any federal law or state statute, all records maintained or kept on file by any public agency, whether or not such records are required by any law or by any rule or regulation, shall be public records and every person shall have the right to (1) inspect such records promptly during regular office or business hours, (2) copy such records in accordance with subsection (g) of section 1-212, or (3) receive a copy of such records in accordance with section 1-212. Any agency rule or regulation, or part thereof, that conflicts with the provisions of this subsection or diminishes or curtails in any way the rights granted by this subsection shall be void. Each such agency shall keep and maintain all public records in its custody at its regular office or place of business in an accessible place and, if there is no such office or place of business, the public records pertaining to such agency shall be kept in the office of the clerk of the political subdivision in which such public agency is located or of the Secretary of the State, as the case may be. Any certified record hereunder attested as a true copy by the clerk, chief or deputy of such agency or by such other person designated or empowered by law to so act, shall be competent evidence in any court of this state of the facts contained therein.

(b) Nothing in the Freedom of Information Act shall be construed to require disclosure of:

(1) Preliminary drafts or notes provided the public agency has determined that the public interest in withholding such documents clearly outweighs the public interest in disclosure;

(2) Personnel or medical files and similar files the disclosure of which would constitute an invasion of personal privacy;

(3) Records of law enforcement agencies not otherwise available to the public which records were compiled in connection with the detection or investigation of crime, if the disclosure of said records would not be in the public interest because it would result in the disclosure of (A) the identity of informants not otherwise known or the identity of witnesses not otherwise known whose safety would be endangered or who would be subject to threat or intimidation if their identity was made known, (B) signed statements of witnesses, (C) information to be used in a prospective law enforcement action if

school in a regional school district to the board of selectmen or town board of finance, as the case may be, of the town wherein the student resides for the purpose of verifying tuition payments made to such school;

(12) Any information obtained by the use of illegal means;

(13) Records of an investigation or the name of an employee providing information under the provisions of section 4-61dd;

(14) Adoption records and information provided for in sections 45a-746, 45a-750 and 45a-751;

(15) Any page of a primary petition, nominating petition, referendum petition or petition for a town meeting submitted under any provision of the general statutes or of any special act, municipal charter or ordinance, until the required processing and certification of such page has been completed by the official or officials charged with such duty after which time disclosure of such page shall be required;

(16) Records of complaints, including information compiled in the investigation thereof, brought to a municipal health authority pursuant to chapter 368e or a district department of health pursuant to chapter 368f, until such time as the investigation is concluded or thirty days from the date of receipt of the complaint, whichever occurs first;

(17) Educational records which are not subject to disclosure under the Family Educational Rights and Privacy Act, 20 USC 1232g;

(18) Records, the disclosure of which the Commissioner of Correction, or as it applies to Whiting Forensic Division facilities of the Connecticut Valley Hospital, the Commissioner of Mental Health and Addiction Services, has reasonable grounds to believe may result in a safety risk, including the risk of harm to any person or the risk of an escape from, or a disorder in, a correctional institution or facility under the supervision of the Department of Correction or Whiting Forensic Division facilities. Such records shall include, but are not limited to:

(A) Security manuals, including emergency plans contained or referred to in such security manuals;

(B) Engineering and architectural drawings of correctional institutions or facilities or Whiting Forensic Division facilities;

(C) Operational specifications of security systems utilized by the Department of Correction at any correctional institution or facility or Whiting Forensic Division facilities, except that a general description of any such security system and the cost and quality of such system may be disclosed;

(D) Training manuals prepared for correctional institutions and facilities or Whiting Forensic Division facilities that describe, in any manner, security procedures, emergency plans or security equipment;

(v) Internal security audits of government-owned or leased institutions or facilities;

(vi) Minutes or records of meetings, or portions of such minutes or records, that contain or reveal information relating to security or other records otherwise exempt from disclosure under this subdivision;

(vii) Logs or other documents that contain information on the movement or assignment of security personnel;

(viii) Emergency plans and emergency preparedness, response, recovery and mitigation plans, including plans provided by a person to a state agency or a local emergency management agency or official; and

(ix) With respect to a water company, as defined in section 25-32a, that provides water service: Vulnerability assessments and risk management plans, operational plans, portions of water supply plans submitted pursuant to section 25-32d that contain or reveal information the disclosure of which may result in a security risk to a water company, inspection reports, technical specifications and other materials that depict or specifically describe critical water company operating facilities, collection and distribution systems or sources of supply;

(20) Records of standards, procedures, processes, software and codes, not otherwise available to the public, the disclosure of which would compromise the security or integrity of an information technology system;

(21) The residential, work or school address of any participant in the address confidentiality program established pursuant to sections 54-240 to 54-240o, inclusive;

(22) The electronic mail address of any person that is obtained by the Department of Transportation in connection with the implementation or administration of any plan to inform individuals about significant highway or railway incidents;

(23) The name or address of any minor enrolled in any parks and recreation program administered or sponsored by any public agency;

(24) Responses to any request for proposals or bid solicitation issued by a public agency or any record or file made by a public agency in connection with the contract award process, until such contract is executed or negotiations for the award of such contract have ended, whichever occurs earlier, provided the chief executive officer of such public agency certifies that the public interest in the disclosure of such responses, record or file is outweighed by the public interest in the confidentiality of such responses, record or file.

(c) Whenever a public agency receives a request from any person confined in a correctional institution or facility or a Whiting Forensic Division facility, for disclosure of any public record under the Freedom of Information Act, the public agency shall promptly notify the Commissioner of Correction or the Commissioner of Mental Health

regulating the erection, construction, alteration, maintenance, sanitation, ventilation or occupancy of such buildings; and

(3) The names of firms obtaining bid documents from any state agency. (P.A. 57-428, §1; P.A. 63-260; P.A. 67-723, §1; P.A. 69-193; P.A. 71-193; P.A. 75-342, §2; P.A. 76-294; P.A. 77-609, §2; P.A. 79-119; P.A. 79-324; P.A. 79-575, §2; P.A. 79-599, §3; P.A. 80-483, §1; P.A. 81-40, §2; P.A. 81-431, §1; P.A. 81-448, §2; P.A. 83-436; P.A. 84-112, §1; P.A. 84-311, §2; P.A. 85-577, §22; P.A. 90-335, §1; P.A. 91-140, §2; P.A. 94-246, §14; P.A. 95-233; P.A. 96-130, §37; P.A. 97-47, §4; P.A. 97-112, §2; P.A. 97-293, §14; P.A. 99-156, §1; P.A. 00-66, §5; P.A. 00-69, §3; P.A. 00-134, §1; P.A. 00-136, §2; June Sp. Sess. P.A. 00-1, §20; P.A. 01-26, §1; P.A. 02-133, §§1, 2; P.A. 02-137, §2; P.A. 03-200, §17; June 30, Sp. Sess., P.A. 03-6, §104; P.A. 05-287, §26; P.A. 07-202, §12; P.A. 07-213, §22; P.A. 07-236, §5; P.A. 08-18, §1.)

Sec. 1-211. (Formerly Sec. 1-19a). Disclosure of computer-stored public records. Contracts. Acquisition of system, equipment, software to store or retrieve nonexempt public records. (a) Any public agency which maintains public records in a computer storage system shall provide, to any person making a request pursuant to the Freedom of Information Act, a copy of any nonexempt data contained in such records, properly identified, on paper, disk, tape or any other electronic storage device or medium requested by the person, if the agency can reasonably make such copy or have such copy made. Except as otherwise provided by state statute, the cost for providing a copy of such data shall be in accordance with the provisions of section 1-212.

(b) Except as otherwise provided by state statute, no public agency shall enter into a contract with, or otherwise obligate itself to, any person if such contract or obligation impairs the right of the public under the Freedom of Information Act to inspect or copy the agency's nonexempt public records existing on-line in, or stored on a device or medium used in connection with, a computer system owned, leased or otherwise used by the agency in the course of its governmental functions.

(c) On and after July 1, 1992, before any public agency acquires any computer system, equipment or software to store or retrieve nonexempt public records, it shall consider whether such proposed system, equipment or software adequately provides for the rights of the public under the Freedom of Information Act at the least cost possible to the agency and to persons entitled to access to nonexempt public records under the Freedom of Information Act. In meeting its obligations under this subsection, each state public agency shall consult with the Department of Information Technology as part of the agency's design analysis prior to acquiring any such computer system, equipment or software. The Department of Information Technology shall adopt written guidelines to assist municipal agencies in carrying out the purposes of this subsection. Nothing in this subsection shall require an agency to consult with said department prior to acquiring a system, equipment or software or modifying software, if such acquisition or modification is consistent with a design analysis for which such agency has previously consulted with said department. The Department of Information Technology shall consult with the Freedom of Information Commission on matters relating to access to and disclosure of public records for the purposes of this subsection. The provisions of this subsection shall not apply to software modifications which would not affect the rights of the public under

(c) A public agency may require the prepayment of any fee required or permitted under the Freedom of Information Act if such fee is estimated to be ten dollars or more. The sales tax provided in chapter 219 shall not be imposed upon any transaction for which a fee is required or permissible under this section or section 1-227.

(d) The public agency shall waive any fee provided for in this section when:

(1) The person requesting the records is an indigent individual;

(2) The records located are determined by the public agency to be exempt from disclosure under subsection (b) of section 1-210;

(3) In its judgment, compliance with the applicant's request benefits the general welfare; or

(4) The person requesting the record is an elected official of a political subdivision of the state and the official (A) obtains the record from an agency of the political subdivision in which the official serves, and (B) certifies that the record pertains to the official's duties.

(e) Except as otherwise provided by law, the fee for any person who has the custody of any public records or files for certifying any copy of such records or files, or certifying to any fact appearing therefrom, shall be for the first page of such certificate, or copy and certificate, one dollar; and for each additional page, fifty cents. For the purpose of computing such fee, such copy and certificate shall be deemed to be one continuous instrument.

(f) The Secretary of the State, after consulting with the chairperson of the Freedom of Information Commission, the Commissioner of Correction and a representative of the Judicial Department, shall propose a fee structure for copies of public records provided to an inmate, as defined in section 18-84, in accordance with subsection (a) of this section. The Secretary of the State shall submit such proposed fee structure to the joint standing committee of the General Assembly having cognizance of matters relating to government administration, not later than January 15, 2000.

(g) Any individual may copy a public record through the use of a hand-held scanner. A public agency may establish a fee structure not to exceed twenty dollars for an individual to pay each time the individual copies records at the agency with a hand-held scanner. As used in this section, "hand-held scanner" means a battery operated electronic scanning device the use of which (1) leaves no mark or impression on the public record, and (2) does not unreasonably interfere with the operation of the public agency. (1949 Rev., §3625; P.A. 59-352, §1; P.A. 75-342, §5; P.A. 77-609, §3; P.A. 89-251, §56; P.A. 90-307, §4; P.A. 91-347, §2; P.A. 93-188, §1; P.A. 94-112, §1; P.A. 95-144, §1; P.A. 97-47, §§2, 3; June 18 Sp. Sess., P.A. 97-9, §25; P.A. 99-71, §2; P.A. 99-156, §2; P.A. 00-66, §6; P.A. 02-137, §3; P.A. 09-03, §140.)

representative of the notice or, if there is no evidence of receipt of written notice, not later than nine business days from the date the notice is actually mailed, sent, posted or otherwise given. Each objection filed under this subsection shall be on a form prescribed by the public agency, which shall consist of a statement to be signed by the employee or the employee's collective bargaining representative, under the penalties of false statement, that to the best of his knowledge, information and belief there is good ground to support it and that the objection is not interposed for delay. Upon the filing of an objection as provided in this subsection, the agency shall not disclose the requested records unless ordered to do so by the Freedom of Information Commission pursuant to section 1-206. Failure to comply with a request to inspect or copy records under this section shall constitute a denial for the purposes of section 1-206. Notwithstanding any provision of this subsection or subsection (b) of section 1-206 to the contrary, if an employee's collective bargaining representative files a written objection under this subsection, the employee may subsequently approve the disclosure of the records requested by submitting a written notice to the public agency. (P.A. 73-271; P.A. 78-331, §1; P.A. 87-285, §1; P.A. 88-353, §1; P.A. 92-207, §1.)

Sec. 1-214a. Disclosure of public agency termination, suspension or separation agreement containing confidentiality provision. Any agreement entered into by any public agency, as defined in section 1-200, with an employee or personal services contractor providing for the termination, suspension or separation from employment of such employee or the termination or suspension of the provision of personal services by such contractor, as the case may be, that contains a confidentiality provision that prohibits or restricts such public agency from disclosing the existence of the agreement or the cause or causes for such termination, suspension or separation including, but not limited to, alleged or substantiated sexual abuse, sexual harassment, sexual exploitation or sexual assault by such employee or contractor, shall be subject to public disclosure under this chapter. (P.A. 06-132, §1.)

Sec. 1-215. (Formerly Sec. 1-20b). Record of an arrest as public record. Exception. (a) Notwithstanding any provision of the general statutes to the contrary, and except as otherwise provided in this section, any record of the arrest of any person, other than a juvenile, except a record erased pursuant to chapter 961a, shall be a public record from the time of such arrest and shall be disclosed in accordance with the provisions of section 1-212 and subsection (a) of section 1-210, except that disclosure of data or information other than that set forth in subdivision (1) of subsection (b) of this section shall be subject to the provisions of subdivision (3) of subsection (b) of section 1-210. Any personal possessions or effects found on a person at the time of such person's arrest shall not be disclosed unless such possessions or effects are relevant to the crime for which such person was arrested.

(b) For the purposes of this section, "record of the arrest" means (1) the name and address of the person arrested, the date, time and place of the arrest and the offense for which the person was arrested, and (2) at least one of the following, designated by the law enforcement agency: The arrest report, incident report, news release or other similar report of the arrest of a person. (P.A. 83-272, §1; P.A. 94-117, §4; P.A. 94-246, §13.)

described in section 14-10 of the 2008 supplement to the general statutes. (P.A. 95-163; P.A. 96-83, §1; P.A. 97-219, §2; P.A. 99-26, §27; P.A. 99-77, §1; P.A. 99-156, §3; P.A. 01-186, §17; P.A. 02-53, §1; P.A. 04-234, §2; P.A. 04-257, §114; P.A. 05-108, §2; P.A. 08-120, §1; P.A. 08-186, §1.)

Sec. 1-218. Certain contracts for performance of governmental functions. Records and files subject to Freedom of Information Act. Each contract in excess of two million five hundred thousand dollars between a public agency and a person for the performance of a governmental function shall (1) provide that the public agency is entitled to receive a copy of records and files related to the performance of the governmental function, and (2) indicate that such records and files are subject to the Freedom of Information Act and may be disclosed by the public agency pursuant to the Freedom of Information Act. No request to inspect or copy such records or files shall be valid unless the request is made to the public agency in accordance with the Freedom of Information Act. Any complaint by a person who is denied the right to inspect or copy such records or files shall be brought to the Freedom of Information Commission in accordance with the provisions of sections 1-205 and 1-206. (P.A. 01-169, §2.)

Sec. 1-219. Veterans' military records. (a) As used in this section: (1) "Armed forces" means the Army, Navy, Marine Corps, Coast Guard or Air Force of the United States; (2) "veteran" means any person honorably discharged from, or released under honorable conditions from active service or reserve status in the armed forces; (3) "military discharge document" means a United States Department of Defense form, including, but not limited to, a DD 214 form, or any valid paper that evidences the service, discharge or retirement of a veteran from the armed forces that contains personal information such as a service number or Social Security number; (4) "person" means any individual or entity, including, but not limited to, a relative of a veteran, a licensed funeral director or embalmer, an attorney-at-law, an attorney-in-fact, an insurance company or a veterans' advocate; and (5) "public agency" or "agency" means a public agency, as defined in section 1-200.

(b) A veteran or designee may file a military discharge document with the town clerk of the town in which the veteran resides or with any other public agency if the military discharge document is related to the business of the town or other agency, and the town or agency shall maintain and record the military discharge document in accordance with this section.

(c) Notwithstanding any provision of chapter 55, or any provision of section 11-8 or 11-8a, any military discharge document filed by or on behalf of a veteran with a public agency before, on or after October 1, 2002, except a military discharge document recorded before October 1, 2002, on the land records of a town, shall be retained by the agency separate and apart from the other records of the agency. The contents of such document shall be confidential for at least seventy-five years from the date the document is filed with the public agency, except that:

(1) The information contained in the document shall be available to the veteran, or a conservator of the person of the veteran or a conservator of the estate of the veteran, at all times;

The chief executive officer of any multitown district or agency shall file, not later than January thirty-first of each year, with the clerk of each municipal member of such district or agency, the schedule of regular meetings of such public agency for the ensuing year, and no such meeting of any such public agency shall be held sooner than thirty days after such schedule has been filed.

(c) The agenda of the regular meetings of every public agency, except for the General Assembly, shall be available to the public and shall be filed, not less than twenty-four hours before the meetings to which they refer, (1) in such agency's regular office or place of business, and (2) in the office of the Secretary of the State for any such public agency of the state, in the office of the clerk of such subdivision for any public agency of a political subdivision of the state or in the office of the clerk of each municipal member of any multitown district or agency. For any such public agency of the state, such agenda shall be posted on the public agency's and the Secretary of the State's web sites. Upon the affirmative vote of two-thirds of the members of a public agency present and voting, any subsequent business not included in such filed agendas may be considered and acted upon at such meetings.

(d) Notice of each special meeting of every public agency, except for the General Assembly, either house thereof or any committee thereof, shall be posted not less than twenty-four hours before the meeting to which such notice refers on the public agency's Internet web site, if available, and given not less than twenty-four hours prior to the time of such meeting by filing a notice of the time and place thereof in the office of the Secretary of the State for any such public agency of the state, in the office of the clerk of such subdivision for any public agency of a political subdivision of the state and in the office of the clerk of each municipal member for any multitown district or agency. The secretary or clerk shall cause any notice received under this section to be posted in his office. Such notice shall be given not less than twenty-four hours prior to the time of the special meeting; provided, in case of emergency, except for the General Assembly, either house thereof or any committee thereof, any such special meeting may be held without complying with the foregoing requirement for the filing of notice but a copy of the minutes of every such emergency special meeting adequately setting forth the nature of the emergency and the proceedings occurring at such meeting shall be filed with the Secretary of the State, the clerk of such political subdivision, or the clerk of each municipal member of such multitown district or agency, as the case may be, not later than seventy-two hours following the holding of such meeting. The notice shall specify the time and place of the special meeting and the business to be transacted. No other business shall be considered at such meetings by such public agency. In addition, such written notice shall be delivered to the usual place of abode of each member of the public agency so that the same is received prior to such special meeting. The requirement of delivery of such written notice may be dispensed with as to any member who at or prior to the time the meeting convenes files with the clerk or secretary of the public agency a written waiver of delivery of such notice. Such waiver may be given by telegram. The requirement of delivery of such written notice may also be dispensed with as to any member who is actually present at the meeting at the time it convenes. Nothing in this section shall be construed to prohibit any agency from adopting more stringent notice requirements.

appear and be heard by the court or judge granting such injunction with regard to dissolving or modifying the same and, after hearing the parties and upon a determination that such meeting should not be open to the public, said court or judge may dissolve or modify the injunction. Any action taken by a judge upon any such application shall be immediately certified to the court to which such proceedings are returnable. (P.A. 67-851, §1; P.A. 69-706; P.A. 74-183, §161; P.A. 75-342, §12; P.A. 76-435, §24; P.A. 76-436, §562; P.A. 77-609, §5; P.A. 78-280, §1; P.A. 05-288, §3.)

Sec. 1-227. (Formerly Sec. 1-21c). Mailing of notice of meetings to persons filing written request. Fees. The public agency shall, where practicable, give notice by mail of each regular meeting, and of any special meeting which is called, at least one week prior to the date set for the meeting, to any person who has filed a written request for such notice with such body, except that such body may give such notice as it deems practical of special meetings called less than seven days prior to the date set for the meeting. Such notice requirement shall not apply to the General Assembly, either house thereof or to any committee thereof. Any request for notice filed pursuant to this section shall be valid for one year from the date on which it is filed unless a renewal request is filed. Renewal requests for notice shall be filed within thirty days after January first of each year. Such public agency may establish a reasonable charge for sending such notice based on the estimated cost of providing such service. (P.A. 75-342, §7.)

Sec. 1-228. (Formerly Sec. 1-21d). Adjournment of meetings. Notice. The public agency may adjourn any regular or special meeting to a time and place specified in the order of adjournment. Less than a quorum may so adjourn from time to time. If all members are absent from any regular meeting the clerk or the secretary of such body may declare the meeting adjourned to a stated time and place and shall cause a written notice of the adjournment to be given in the same manner as provided in section 1-225, for special meetings, unless such notice is waived as provided for special meetings. A copy of the order or notice of adjournment shall be conspicuously posted on or near the door of the place where the regular or special meeting was held, within twenty-four hours after the time of the adjournment. When an order of adjournment of any meeting fails to state the hour at which the adjourned meeting is to be held, it shall be held at the hour specified for regular meetings, by ordinance, resolution, by law or other rule. (P.A. 75-342, §8.)

Sec. 1-229. (Formerly Sec. 1-21e). Continued hearings. Notice. Any hearing being held, or noticed or ordered to be held, by the public agency at any meeting may by order or notice of continuance be continued or recontinued to any subsequent meeting of such agency in the same manner and to the same extent set forth in section 1-228, for the adjournment of meeting, provided, that if the hearing is continued to a time less than twenty-four hours after the time specified in the order or notice of hearing, a copy of the order or notice of continuance of hearing shall be posted on or near the door of the place where the hearing was held immediately following the meeting at which the order or declaration of continuance was adopted or made. (P.A. 75-342, §9.)

Sec. 1-230. (Formerly Sec. 1-21f). Regular meetings to be held pursuant to regulation, ordinance or resolution. The public agency shall provide by regulation, in the case of a state agency, or by ordinance or resolution in the case of an agency of a

Sec. 1-241. (Formerly Sec. 1-211). Injunctive relief from frivolous, unreasonable or harassing freedom of information appeals. A public agency, as defined in subdivision (1) of section 1-200, may bring an action to the Superior Court against any person who was denied leave by the Freedom of Information Commission to have his appeal heard by the commission under subsection (b) of section 1-206 because the commission determined and found that such appeal or the underlying request would perpetrate an injustice or would constitute an abuse of the commission's administrative process. The action authorized under this section shall be limited to an injunction prohibiting such person from bringing any further appeal to the commission which would perpetrate an injustice or would constitute an abuse of the commission's administrative process. If, after such an injunction is ordered, the person subject to the injunction brings a further appeal to the Freedom of Information Commission and the commission determines that such appeal would perpetrate an injustice or would constitute an abuse of the commission's administrative process, such person shall be conclusively deemed to have violated the injunction and such agency may seek further injunctive and equitable relief, damages, attorney's fees and costs, as the court may order. (P.A. 93-191, §2; P.A. 97-47, §14.)

Sec. 1-242. Actions involving provisions of the Freedom of Information Act. Notice of litigation to the Freedom of Information Commission. Intervention by commission. (a) In any action involving the assertion that a provision of the Freedom of Information Act has been violated or constitutes a defense, the court to which such action is brought shall make an order requiring the party asserting such violation or defense, as applicable, to provide the Freedom of Information Commission with notice of the action and a copy of the complaint and all pleadings in the action by first-class mail or personal service to the address of the commission's office.

(b) Upon the filing of a verified pleading by the commission, the court to which an action described in subsection (a) of this section is brought may grant the commission's motion to intervene in the action for purposes of participating in any issue involving a provision of the Freedom of Information Act. (P.A. 04-206, §1.)

Secs. 1-243 to 1-259. Reserved for future use.

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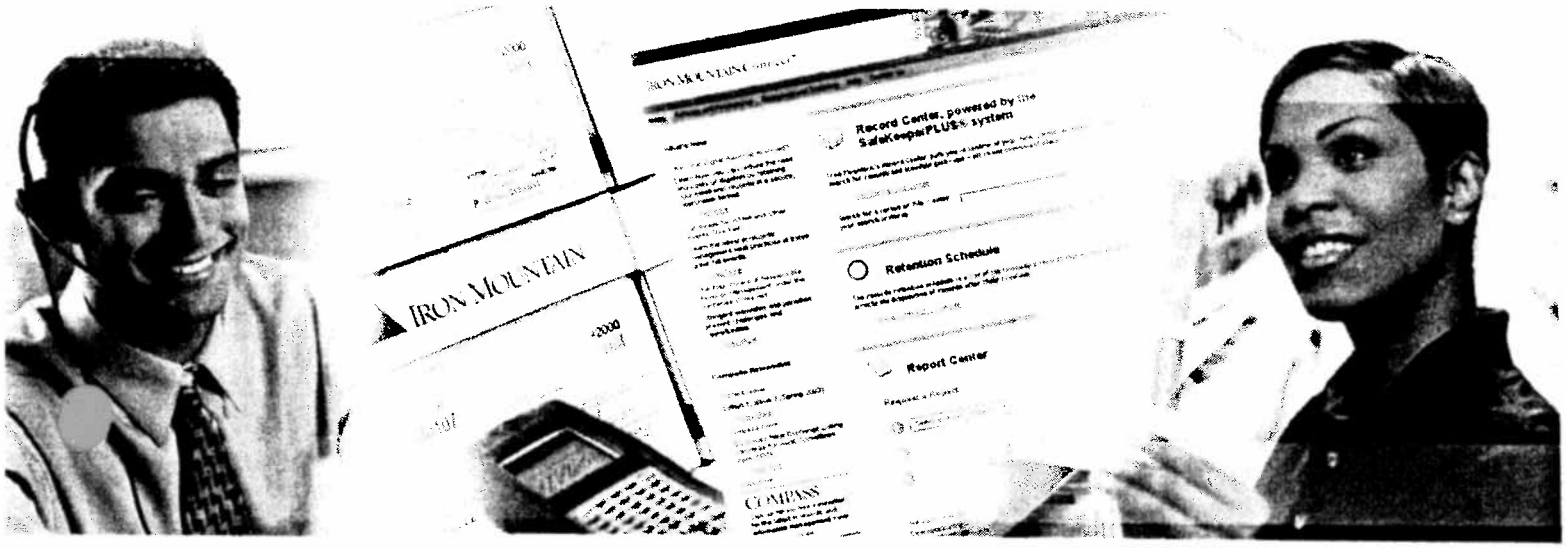

Customer Handbook

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Information Management Solutions

The face of records management and the definition of 'business records', as you've come to know them, have changed. It's no longer just active versus inactive files or items that you put into storage at an off-site location and forget about. Business records today encompass a much broader spectrum of information that transcends traditional recordkeeping practices.

However, it's not just the changing definition of business records or their formats to consider. It's also legislation and compliance, legal exposure, privacy and security regulations, disaster recovery and business continuity planning – not to mention the day-to-day factors such as space constraints due to increased volume, the need to control costs, and your ability to access your information when you need it. Smart, well-run organizations recognize this ever-changing records management environment and adapt accordingly by sharing the responsibility with a reliable resource.

Iron Mountain is the world's trusted partner for outsourced records and information management services. Founded in 1951, the Company services more than 310,000 Customers throughout the United States, Canada, Europe, Latin America and Asia Pacific. Our experience and records management expertise enable us to analyze your business from a unique perspective. Additionally, we can provide your organization with the full range of services essential to maintaining the health of your records management program.

Control, Consistency and Access Through Technology

Today's business environment demands accurate information and quick turn-around times. Not to mention, the underlying responsibilities of records management have shifted towards mastering current compliance requirements and applying them to your records and information management program. Iron Mountain can help you achieve consistency by making it easy to integrate standard, company-wide retention schedules and policies into everyday practices.

We put you in control. Our technology solutions enable you to manage extensive inventory databases and sophisticated indexing, as well as track down your shipment in transit – right from your desktop. We call this robust technology infrastructure the Iron Mountain Connect which is powered by the SafeKeeperPLUS® system – Iron Mountain's proprietary inventory management software. Our IT professionals are continually developing next-generation solutions based on *your* records management requirements.

Records Management Professionals, At Your Service

Managing your business records today involves a lot more than it use to. At a minimum, it requires planning, expertise, experience, and resources – from scanning barcodes, to listing descriptive information, to archiving your records, to placing your order, to retrieving your information when you need it. A vast array of products and services and state-of-the-art technology is impressive, but it means very little if not backed by great service. What sets Iron Mountain apart from the others? Simply put, it's our people.

Iron Mountain's ability to service your records management requirements professionally and efficiently is a direct result of our team of specialists who are dedicated to ensuring your satisfaction by understanding your business needs. Expert consultants, friendly and knowledgeable customer service representatives, experienced account managers, around-the-clock technical support, and courteous drivers are just a few of the hundreds at your service – every day.

Our goal is to build a lasting, mutually beneficial relationship with you. Whether you need us to pick up your records or walk you through our online system, help is just a phone call away, 24 hours a day, 7 days a week, 365 days a year.

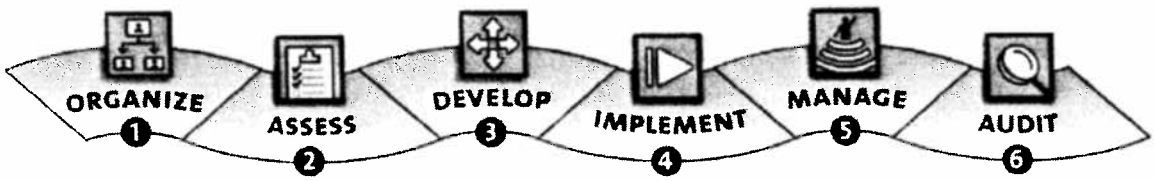
The Iron Mountain Connect™ Records Management Portal

Compliant Records Management — No Longer Optional

The Iron Mountain Connect web-based system provides you the tools you need to implement a comprehensive, compliant records management program.

Utilize the numerous resources available on the Iron Mountain Connect system, such as the Record Center, which provides instant access to your records, the Retention Schedule to review retention policies, and the Report Center to manage program compliance.

Iron Mountain Connect can transform your organization's records management program into a compliance program by providing the necessary tools to integrate records management best practices into your everyday business discipline. Use the Iron Mountain Connect system as a guide through every stage in the development of a Compliant Records Management Program.



6 Stages of Compliant Records Management

Organize

Start by determining the scope of your organization's records management program and what staffing is necessary to support a compliance program.

Records Management 101 — Review Iron Mountain's information repository, which offers advice and best practices on program auditing, indexing for quick access and proper disposition of records.

Assess

As part of the assessment phase, you should identify all of your organization's records, their physical location and legal retention requirements. If your records are consolidated at Iron Mountain, the Iron Mountain Connect system can provide a single view of your entire program.

Develop

Develop a comprehensive retention schedule and standard, company-wide policies to set the foundation for a credible and consistent records management program.

Tips and Best Practices — View best practice guidelines on corporate records retention policies posted on the Iron Mountain Connect system.

Implement

The Iron Mountain Connect system plays a vital role during the implementation and phased launch of a compliant records management program. By providing program administrators instant access to records and the flexibility to tailor specific training programs, the Iron Mountain Connect system facilitates implementation and adoption.

Access Information Instantly — The Record Center in Iron Mountain Connect maintains an electronic index of descriptive data on your records. This system handles search and retrieval, enforces the retention schedule and manages the health and maintenance of your records management program. The Record Center 's predictive search engine takes advantage of everything Iron Mountain has learned about how people really retrieve records. The result: you find your cartons or files fast.

Schedule Services at Your Convenience — Use the Record Center to request pickup and delivery anytime and order supplies from Iron Mountain as you need them.

Customize Content, Personalize Views — Administrators can upload records management policies and procedures specific to your organization and control what modules display for which users at an individual or group level. This can aid in training and adoption as materials are centralized and users only access approved information.

Manage

Managing long-term program maintenance and adoption is vital to establishing a culture that projects good faith in the compliance of their records management program. With features such as built-in retention capability, the Iron Mountain Connect system enforces best practices such as assigning hold codes to suspend the destruction of records. Flexible administrative architecture provides control over program users.

Manage User Access — Create a security structure that fits your specific business needs. Administrators govern a security model with up to three-tiers that create, edit, and manage users on an individual or group basis. Add and remove privileges or organizational access from one or multiple users easily.

Provide Consistent Records Classification — Define data validation rules to ensure cartons and files are being added in accordance with your records management program.

Manage and Enforce Your Company's Retention Schedule — Systematically enforce retention for all records, as the integrity of the retention schedule is the foundation of a compliant program.

Manage Disposition of Records Through Hold Codes — Apply hold codes on individual boxes, departments, record series, or accounts to prevent disposition when necessary.

Control Data Entry — Customize data entry to enable consistent classification and management of records to fit your business needs.

Audit

Use the Iron Mountain Connect records management system to perform periodic checks and audits necessary to ensure program continuance.

The Report Center provides you with the reports you need to effectively monitor and manage your organization's records management program. Ensure that the retention schedule is being followed, records are classified consistently and are destroyed in conjunction with proper disposition. Numerous reports are available in the following categories on demand for your program management needs.

Activity Reports — User data, participation analysis, and activity history.

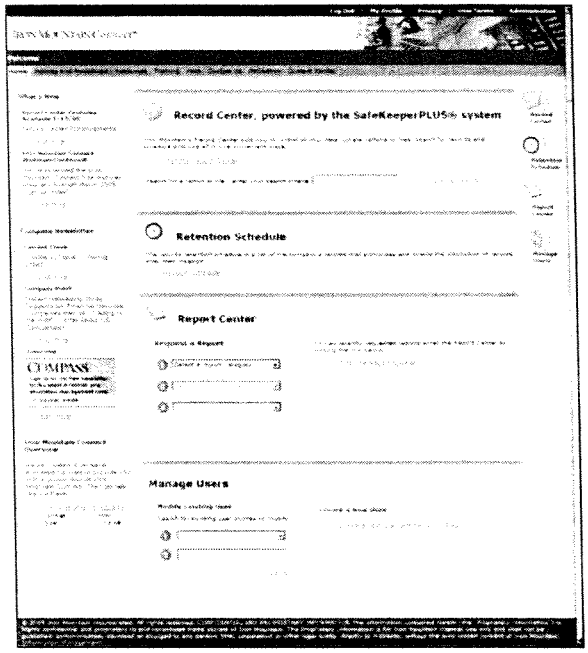
Inventory Reports — Snapshots and historic details of carton and file inventory and inventory quality reports.

Retention Reports — Detailed and summary information related to records classification, retention schedule, hold codes, and destruction eligibility.

Financial Reports — Summary activity and projected forecasts, invoice history, and activity tied to dollars spent.

The Iron Mountain Connect™ Features and Benefits

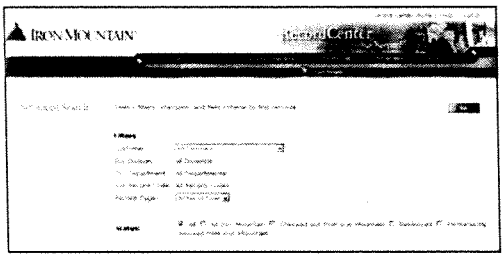
The Iron Mountain Connect portal is your online connection to Iron Mountain, providing the tools necessary to manage records and information assets in today's regulatory environment. Iron Mountain Connect puts you in control, transforming records storage into compliant records and information management programs.



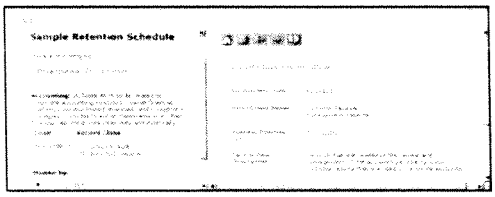
Take advantage of the knowledge resources available on the Iron Mountain Connect system.

Tips And Practices — Industry white papers on best practices in compliant records and information management.

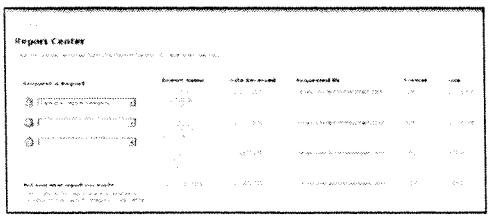
Regulatory Resources — Regulations that affect the archiving of company information assets.



Record Center — Your online, anytime connection to Iron Mountain and your records. Use Record Center to schedule transactions and order supplies, at your convenience. Locate inventory fast using our innovative search technology.

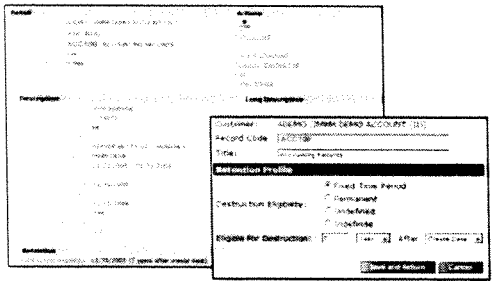


Retention Schedule — Streamline the adoption of your company's retention policy, ensuring compliance. Users can view the company retention schedule from one central location to govern the proper retention and disposition of records.

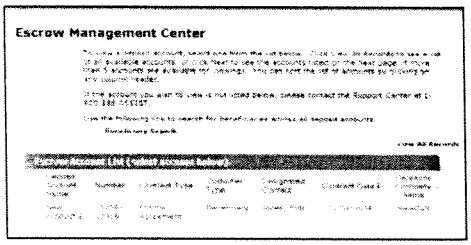


Report Center — Access information vital for effective program control. A variety of reports are available on account activity, inventory retention and program financials.

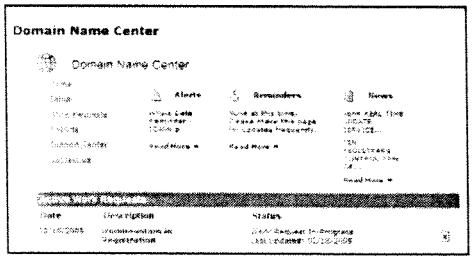
The Iron Mountain Connect™ Features and Benefits



System Driven Retention — The Record Center manages retention in accordance with your corporate retention schedule. Built-in features allow users to view numerous details on their records, including destruction eligibility dates and regulations affecting eligibility. Ensure the timely disposition of records using flexible, user-defined search criteria to report on destruction eligible cartons.



Escrow Management — Gateway to all your escrow management resources. View account information such as deposit data and beneficiary enrollments, conduct escrow transactions and view imaged documents. Increase critical response time with customer information at your fingertips.



Domain Name Center — Secure online service capabilities to efficiently acquire, manage and enforce the use of domain names and trademarks. Decrease the time you spend managing global registration projects and portfolios.

To learn more about the Iron Mountain Connect records management portal, and to get connected, please contact your Iron Mountain Account Manager.

Using Iron Mountain's Services

The Iron Mountain ***Customer Handbook*** is your reference guide for using our services. This manual provides step-by-step instructions for all the tasks you are likely to perform when working with us — your records management services provider.

The following pages summarize the steps needed to:

- ✔ Pack and index your business records
- ✔ Complete the forms required to send these records to storage at Iron Mountain
- ✔ Retrieve records from Iron Mountain
- ✔ Return records to Iron Mountain
- ✔ Understand the various types of available reports
- ✔ Destroy the records that have outlived their usefulness
- ✔ Read and understand your invoice and invoice reports

Iron Mountain Resources

Iron Mountain offers you a team of records management professionals — Account Managers — who are equipped with the latest tools and resources of the records management industry. Account Managers have a critical mission: "To make our Customers' jobs easier while promoting professional records management."

The Account Manager provides the link between you — our Customer — and Iron Mountain. Account Managers make regular Customer visits to ensure your satisfaction and to build long-term partnerships. The Account Management staff provides records management training and education on Iron Mountain's procedures, as well as current legislation and regulatory requirements that could impact your company and its recordkeeping practices.

Please contact your Iron Mountain Account Manager with any questions you might have, or to learn more about Iron Mountain's products and services as described in this ***Handbook***.

Throughout this ***Handbook***, we make reference to several departments within Iron Mountain. For your convenience, we've included their contact information below:

- ► **Online records management with Iron Mountain:** www.imconnect.com
- ► **Information Technology Services' (ITS) Info Center, 24 hours a day, 7 days a week:**
  Phone: 1-800-888-2774 (for technical support only)
- ► **Customer Response, U.S.**
  Phone: 1-800-FastFile **Fax:** 1-800-934-5348
- ► **Customer Response, Canada (within Canada)**
  Phone: 1-800-FastFile **Fax:** 1-800-387-0124; 1-800-316-2464 (Maritimes)
- ► **Iron Mountain's Web site:** www.ironmountain.com

Sending Records

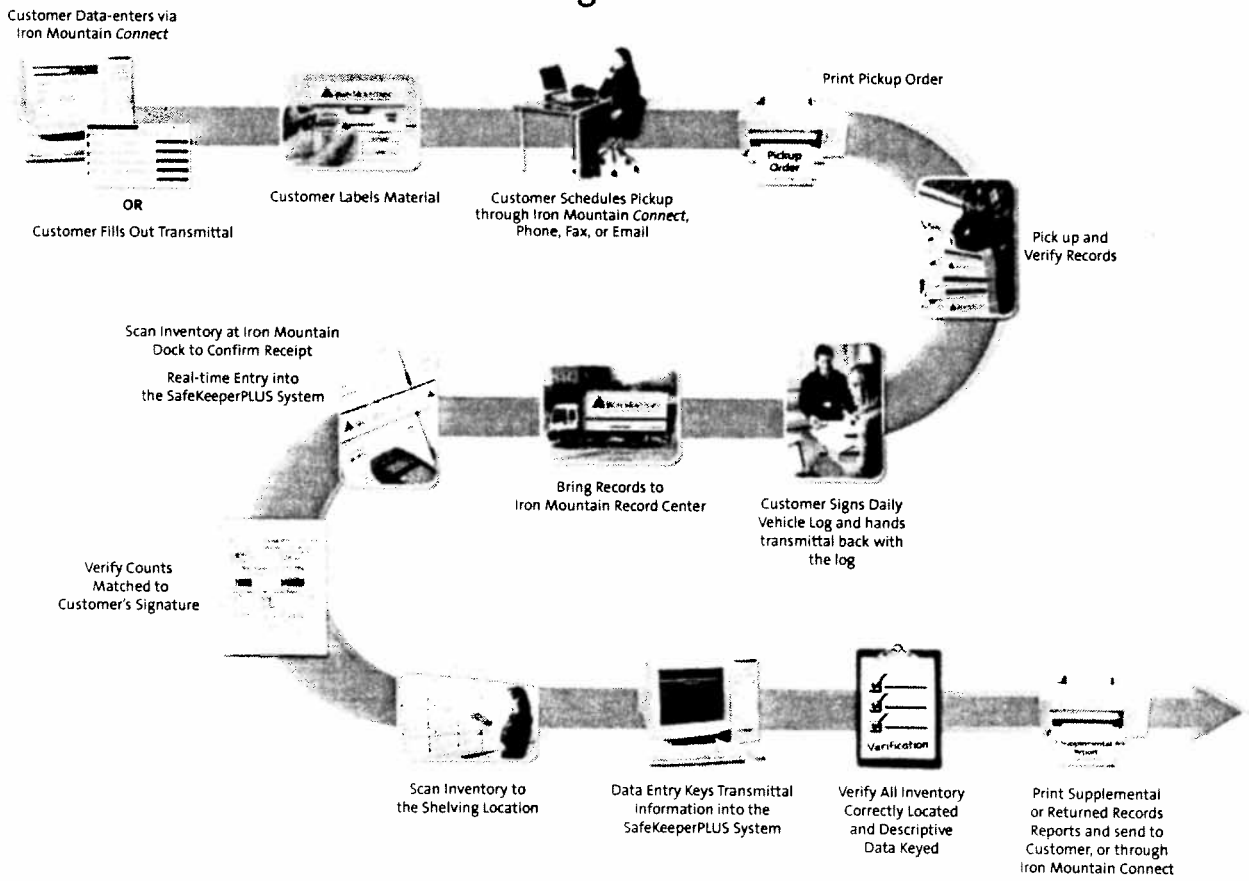
Accuracy is Iron Mountain's number one priority. That's why we've developed checks and balances to ensure that your files are packed, transported, barcoded, indexed, stored, retrieved, and refiled without error. As you pack your records, you'll know precisely what you're keeping and what you're sending off-site. The easy-to-use ***Transmittal*** makes everything clear.

We use barcodes extensively to ensure accuracy. At this stage, we match the barcodes on your ***Transmittal*** with their corresponding cartons. Then we double-check them. Next, we enter the descriptive information listed on your ***Transmittal*** into the SafeKeeperPLUS system.

The Iron Mountain transportation team will carefully move your records to a local record center where they are kept well-protected. They're readily available whenever you need them.

Finally, we'll print out a handy listing of these records. A quick glance at this list and you'll know exactly which of your records are in storage.

Incoming Workflow



Retrieving Information

Iron Mountain can help you quickly retrieve any information you require.

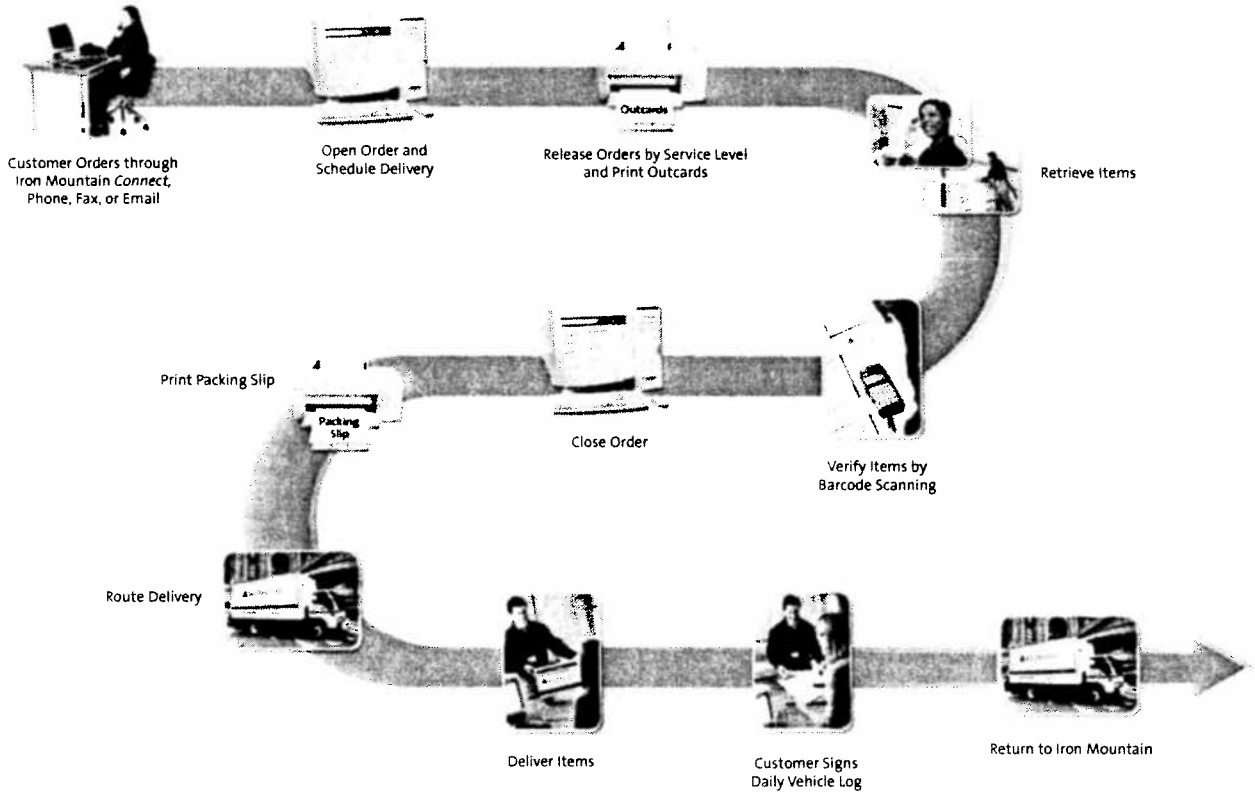
Need a record fast? Just enter your request on your PC, call, fax, or e-mail. Our online capabilities and Customer Service Team can handle your order right over the phone. Our knowledgeable Representatives will access Iron Mountain's SafeKeeperPLUS inventory management system to locate your records.

Then, we'll quickly retrieve your record. For files, we'll place a barcoded outcard in the space from where your file is taken and place an identical barcode on the file. For cartons, we'll place a barcode on the carton itself. When you return your record, we'll match the barcodes, assuring 100% refiling accuracy.

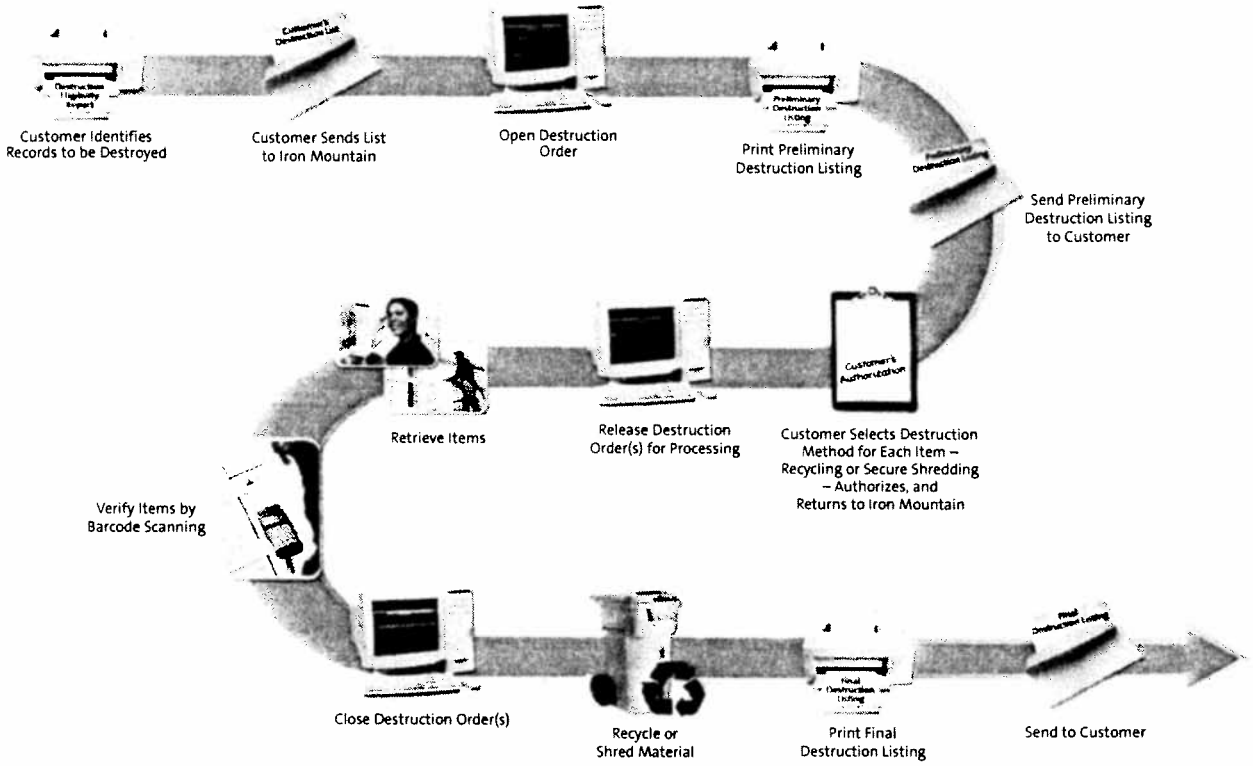
You'll get door-to-door delivery service. The record you need is right in your hands. When you're finished with it, call us. We'll pick it up and store it quickly and accurately.

You can depend on us every time.

Retrieval Workflow



Destruction Workflow



FACTA Overview

In December 2003, the federal government passed the Fair and Accurate Credit Transactions Act of 2003 (FACTA), a new law that affects various aspects of consumer credit.

Under FACTA, certain federal agencies were required to create regulations designed to minimize the risk of identity theft and consumer fraud by enforcing the proper destruction of consumer information. One of the resulting regulations, known as the Disposal Rule, was issued by the Federal Trade Commission in November 2004. Identical rules adopted by the federal banking agencies and the Securities and Exchange Commission now apply to organizations regulated under their authority.

Effective June 1, 2005, the Disposal Rule states that "any person who maintains or otherwise possesses consumer information for a business purpose" is required to properly dispose of the information, whether in electronic or paper form, by "taking reasonable measures to protect against unauthorized access to or use of the information in connection with its disposal."

Computerized Reporting

You will receive an ***Inventory Report*** and a ***Supplemental Report*** to help you find your inventory — when you need it. These reports include information such as the carton barcode number, the description of carton contents, division/department assigned to the carton, arrival date, retention period and much more. Use the ***Reports*** to verify the status and complete storage history of all your records.

Your ***Returned Records Report*** tracks the cartons and files you returned to us.

Destruction Listings display those records eligible for destruction, as well as those that have already been destroyed.

Cost & Activity Reports give you an at-a-glance look at the costs and activities of your records management program. This report helps you pinpoint expenditures, control costs, and allocate expenses to individual cost centers.

Getting Started

To begin using Iron Mountain's services, several forms are available for your use. Contact your Iron Mountain Account Manager to order an adequate supply of the following items:

- ***Access Authorization Forms***
  You will need to complete one or more of these forms in order to authorize individuals from your organization to access and/or destroy your records and information.
- ***Division/Department Forms***
  You will need one form for each division/department to establish the Division and/or Department IDs, as well as to create record codes for your records retention schedule.
- ***Transmittal Sheets/Transmittal Forms***
  You will need multiple *Sheets* for multiple cartons, or one *Form* per carton, to catalogue the descriptive information about each carton to be sent to Iron Mountain.
- ***Barcode Labels***
  You will need one barcode label for each carton to be stored.
- ***File Listing Input Sheets and Green Barcode Labels***
  If you would like to individually list each file within a carton, you will need one or more *File Listing Input Sheets* per carton depending on how many files you have to be individually listed. In addition, you will need green-bordered barcode labels to identify those cartons to be individually listed.
- ***Interfile Labels/Document Insert Labels***
  You will need one *Interfile Label* for each file, or one *Document Insert Label* per document, to be interfiled into cartons already in storage at Iron Mountain.

Additional forms are available to make working with us simple and efficient. They are discussed where appropriate throughout this ***Handbook***.

Contact your Iron Mountain Account Manager for more information about the forms and labels necessary for you to prepare your records for off-site storage at Iron Mountain.

Packing the Carton

When packing records into approved storage containers for off-site storage, please follow these simple guidelines.

Organizing

- **Group like records together.** Like records are defined by a common division, department, or record code. Organizing your records in this fashion ensures accurate retrieval histories and inventory reporting.

  Example: All payroll records from December 2002 for last names ranging between S – Z.

- **Choose a logical system of organization.** Sort the files within a carton in a logical sequence, such as by product type, line of business, customer number, employee name, etc., and, if possible, sequentially by number, alphabetically by name, or in date order.

Packing

- **Letter-sized documents.** Pack files facing the end of the carton to be labeled, i.e., the *InfoPanel* located on one of the handhold sides. Make sure that they face in the same direction. Leave about an inch and a half of free space behind the last file to make retrieving files and interfiling new files easier.
- **Legal-sized documents.** Pack files from side-to-side, making sure that they all face in the same direction. Leave about an inch and a half of free space behind the last file to make retrieving files and interfiling new files easier.

Helpful Hints

- **Don't over-pack the carton.** Pack cartons to a maximum 90% capacity, leaving about an inch and a half of free space behind the last file. This will make it easier to retrieve files and will give you room for future interfiles. Also, a carton that's too densely packed will be too heavy for you to comfortably lift.
- **Don't under-pack the carton.** Files in cartons that are packed at less than 90% capacity may not remain organized, and the carton could collapse under the weight of other cartons once shelved at Iron Mountain. If a carton cannot be packed to capacity, consider combining those files with files in another carton, or keep them in-house until you have an entire carton's worth.
- **Pack only records.** Cartons should house only Official Records (the version of a record that must be retained for the official records retention period). Convenience Records (a duplicate copy, reference material, etc. that is for reference or convenience purposes, and is not designated as an Official Record) should be discarded or handled separately.

Cartons from Iron Mountain

Specially designed for ease of assembly, convenience, strength, and durability, Iron Mountain offers an entire line of cartons and supplies to help you with your records preparation process. They're exactly what you need at a very affordable price. And, all of our records containers are sold in conveniently packaged incremental quantities. Refer to the *Records Management Resources* section of this ***Handbook*** for more information.

For more information about preparing your records for off-site storage, or purchasing storage cartons and supplies, contact your Iron Mountain Account Manager.

Establishing Divisions, Departments, and Record Codes

Most likely, your organization is structured into a logical series of business units called divisions (e.g., Outpatient Care, Hospice Care, Ambulatory), as well as departments within those divisions (e.g., Pediatrics, Cardiology, Obstetrics). You can further break down the types of records (i.e., patient charts, x-rays, ultrasound images) pertinent to each one. Ideally, you should use these same categories when preparing your records for off-site storage.

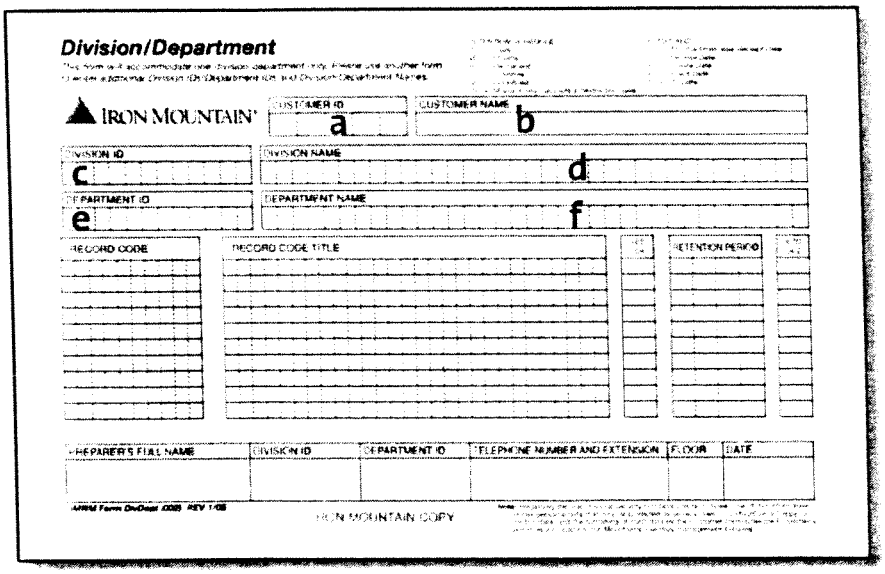
The Iron Mountain ***Division/Department Form*** *helps you to:*

- *Organize your records*
- *Create a list of divisions, departments, and record codes to which your records will be assigned*
- *Establish retention schedules*

The Division/Department Form

One ***Division/Department Form*** must be completed for each new Division* and/or Department created for your account, as well as for new Record Codes. Enter the correct information in the areas indicated, clearly and legibly printing all information. Begin all entries from the left side of each field. Please note that Iron Mountain systems do not recognize leading zeros in the **DIVISION ID**, **DEPARTMENT ID**, and **RECORD CODE** fields. For example, Department 0001234 would be recognized as Department 1234.

***NOTE:** Only customers specifically setup to use Divisions should utilize the **DIVISION** field.



Adding a New Division and/or Department

To establish a new **DIVISION**, complete the ***Division/Department Form*** by printing:

a. Your four- or five-digit **CUSTOMER ID**.

b. Your **CUSTOMER NAME**.

c. The **DIVISION ID*** of the **DEPARTMENT**, using up to 12 alphanumeric characters.
   ***NOTE:** Only customers specifically setup to use Divisions should utilize the **DIVISION** field.

d. The **DIVISION NAME** using up to 35 alphanumeric characters.

To establish a new **DEPARTMENT**, complete the ***Division/Department Form*** by printing the **DIVISION ID** of the **DEPARTMENT** (if you use **DIVISION IDs**; if not, leave the **DIVISION ID** field blank) and:

e. The **DEPARTMENT ID** using up to 10 alphanumeric characters*.
   ***NOTE:** Only customers specifically setup to use extended Department IDs should use blocks 11 and 12.

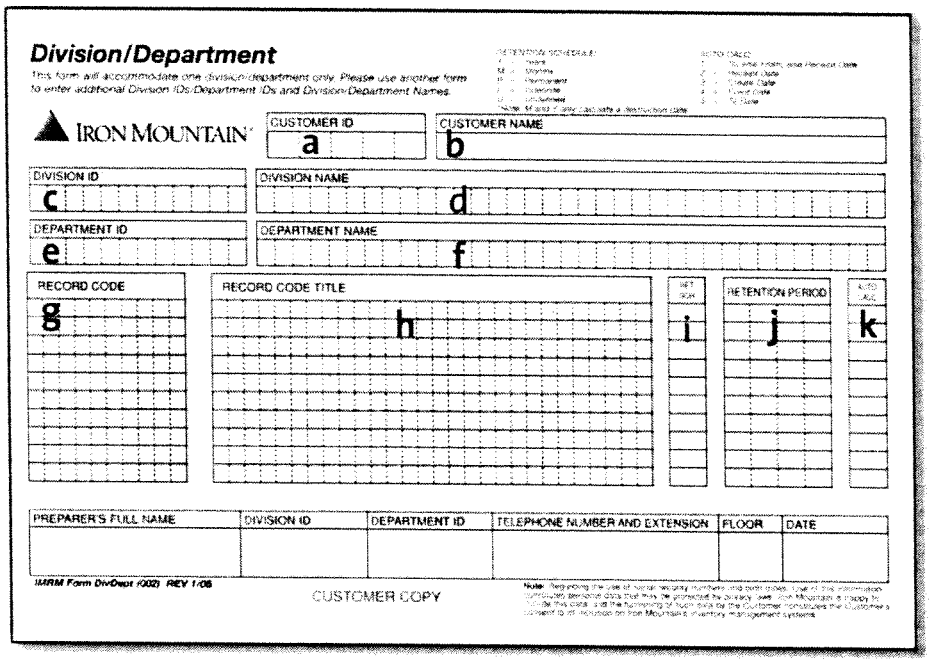
f. The **DEPARTMENT NAME** using up to 35 alphanumeric characters.

Lastly, be sure to include your **NAME**, **DIVISION ID**, **DEPARTMENT ID**, **TELEPHONE NUMBER**, **FLOOR** and **DATE** at the bottom of each ***Form***.

Adding a New Record Code

At Iron Mountain, we refer to the structure that defines record type, descriptions, and retention lengths as a ***Record Code***.

The ongoing and systematic establishment of **RECORD CODES** is most beneficial to a well-organized records management program because it clearly defines exactly how records should be consistently catalogued and may be eligible for destruction, (**RETENTION PERIOD**). This is used if a **Record Code** parameter is set to "validate". Retention will be determined by the **Record Code** on the carton, (**AUTO CALCULATE**), eliminating the need to determine a carton's retention period as part of the ***Transmittal*** completion process.



To establish one or more new **RECORD CODES**, complete the ***Division/Department Form*** by printing:

a. Your **CUSTOMER ID**.

b. Your **CUSTOMER NAME**.

c. The **DIVISION ID*** of the **DEPARTMENT**, using up to 12 alphanumeric characters.
   ***NOTE:** Only customers specifically set up to use Divisions should utilize the **DIVISION** field.

d. The **DIVISION NAME** using up to 35 alphanumeric characters.

e. The **DEPARTMENT ID** using up to 10 alphanumeric characters*.
   ***NOTE:** Only customers specifically setup to use extended Department IDs should use blocks 11 and 12.

f. The **DEPARTMENT NAME** using up to 35 alphanumeric characters.

g. The **RECORD CODE** using up to 6 alphanumeric characters*.
   ***NOTE:** Only customers specifically setup to use extended Record Codes should use blocks 7 through 10.

h. The **RECORD CODE TITLE**, the description of the records to which the code refers, using up to 28 alphanumeric characters.

i. The **RETENTION SCHEDULE CODE**, only customers specifically setup for valid **RECORD CODES** should use the **RETENTION SCHEDULE CODE** field.
   Y = Years **M** = Months **P** = Permanent **I** = Indefinite **U** = Undefined
   ***NOTE:** Customers with a **RECORD CODE** parameter of '0' will only have access to define **RECORD CODES** and **RECORD CODE** titles.

j. The **RETENTION PERIOD**:
This is the number of months or years (based on the **RETENTION SCHEDULE CODE**) that records are assigned to a **RECORD CODE** and are retained before they are eligible for destruction.

***NOTE:** Only if the **RETENTION SCHEDULE CODE** is 'M' or 'Y' should this field be used.

k. The **AUTO CALCULATE CODE**:
By entering one of the following codes, Iron Mountain automatically calculates a **DESTROY DATE**:
1 = To, Else From, Else Receipt Date **2** = Receipt Date **3** = Create Date **4** = Event Date
5 = To Date

***NOTE:** Only if the **RETENTION SCHEDULE CODE** is 'M' or 'Y' should this field be used.

Lastly, be sure to include your **NAME**, **DIVISION ID**, **DEPARTMENT ID**, **TELEPHONE NUMBER** and **EXTENSION**, **FLOOR** and **DATE** at the bottom of each ***Form***.

Automatically Assigning Destruction Dates

One of the benefits of setting up a formal records classification structure for records retention using **RECORD CODES** is the ability to automatically calculate the **DESTROY DATE** of every carton sent to Iron Mountain. This way, the burden of identifying the **DESTROY DATE** is removed from the ***Transmittal*** preparation process.

According to your instructions, Iron Mountain can automatically apply the correct **DESTROY DATE** to a carton based on the **DIVISION/DEPARTMENT ID** and **RECORD CODE** combination from the ***Transmittal***.

To authorize Iron Mountain to use **AUTO CALCULATE DESTROY DATE** processing, submit a letter of authorization indicating which of the following methods of calculation should be used:

"To, Else From, Else Receipt Date" Processing
Assigns the **DESTROY DATE** based on the **TO DATE**, indicated on the ***Transmittal***, plus the **TOTAL RETENTION LENGTH** for the corresponding **RECORD CODE** (if there's no **TO DATE**, the **FROM DATE** will be used; if no **FROM DATE**, then the **RECEIPT DATE**).

"Receipt Date" Processing
Assigns the **DESTROY DATE** based on the **RECEIPT DATE** on inventory plus the Iron Mountain **RETENTION LENGTH** for the corresponding **RECORD CODE**.

"Create Date" Processing
Assigns the **DESTROY DATE** based on the **CREATE DATE** on inventory plus the Iron Mountain **RETENTION LENGTH** for the corresponding **RECORD CODE**. If the **CREATE DATE** is blank, a **DESTROY DATE** or **DESTRUCTION INDICATOR** must be entered.

"Event Date" Processing
Assigns the **DESTROY DATE** based on the **EVENT DATE** on inventory plus the Iron Mountain **RETENTION LENGTH** for the corresponding **RECORD CODE**. If the **EVENT DATE** is blank, a **DESTROY DATE** or **DESTRUCTION INDICATOR** must be entered.

"To Date" Processing
Assigns the **DESTROY DATE** based on the **TO DATE**, indicated on the ***Transmittal***, plus the **TOTAL RETENTION LENGTH** for the corresponding **RECORD CODE**. If the **TO DATE** is blank, a **DESTROY DATE** or **DESTRUCTION INDICATOR** must be entered.

*Contact your Iron Mountain Account Manager for more information about creating an appropriate records retention program for your organization, and how to use the **Division/Department Form**.*

Completing the Transmittal/Using the Barcode Label

A Transmittal is the medium by which a carton's descriptive information is captured. Iron Mountain provides three types of ***Transmittals****:*

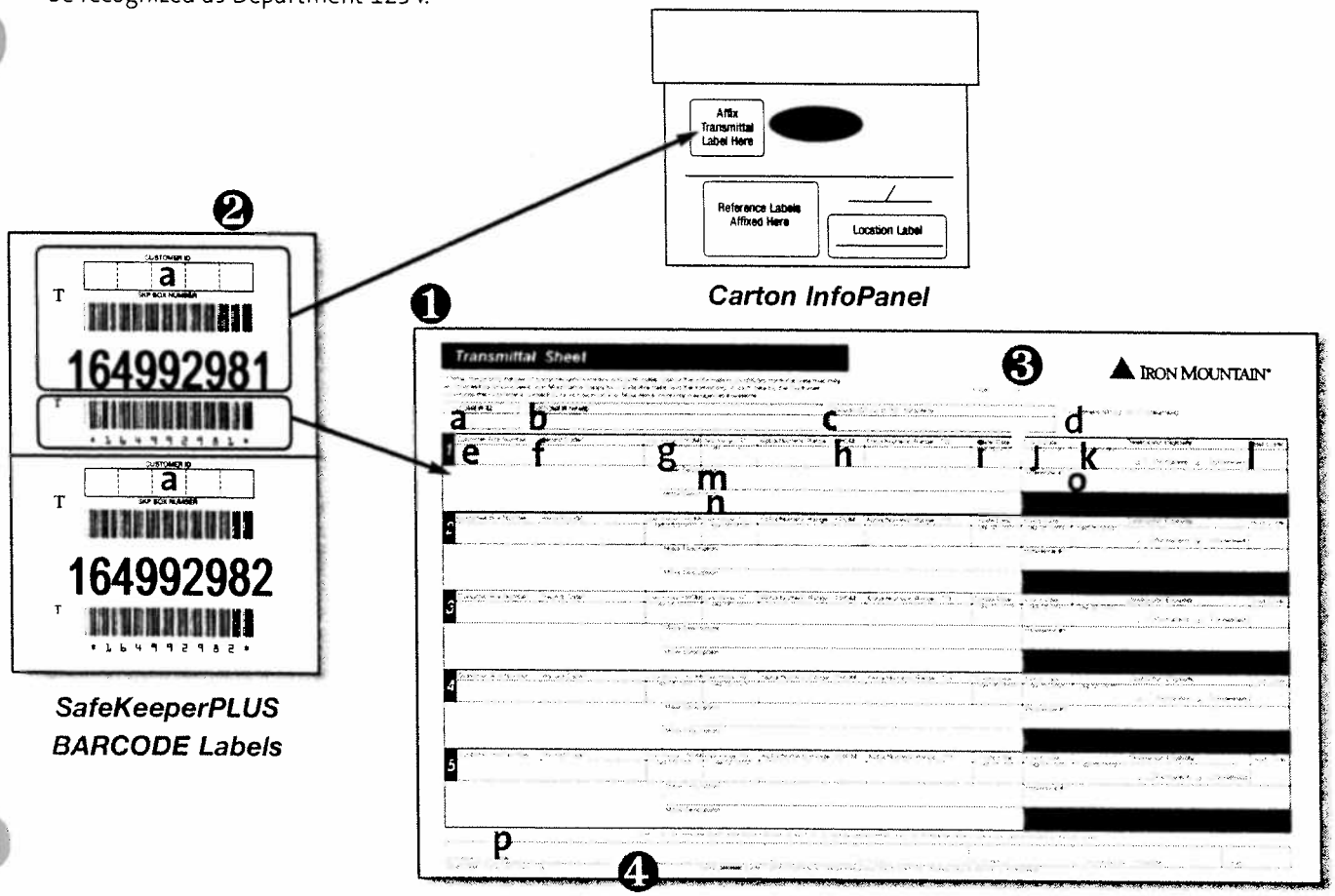
- *The easy-to-complete, multi-carton* ***Transmittal Sheet***
- *The easy-to-complete, one-carton-at-a-time* ***Transmittal Form***
- ***Online data entry*** *by using the Iron Mountain Connect records management portal*

The ***Transmittal Sheet*** *and* ***Transmittal Form*** *are off-line methods. The* ***Transmittal Sheet*** *accommodates the descriptive information for up to five cartons per* ***Sheet****. The* ***Transmittal Form****, in triplicate copy, accepts only one carton per* ***Form****. Online data entry is available in limited capacity to some Iron Mountain Connect users who are authorized to access the Inventory Maintenance menu. Contact your Iron Mountain Account Manager for more information about online data entry.*

The method you use will depend on how your account is set up. Regardless of the method, however, all descriptive information that is captured is provided back to you via inventory reports generated by Iron Mountain.

The Transmittal Sheet

Complete one ***Transmittal Sheet*** for each group of five new cartons to be stored at Iron Mountain. Enter the correct information in the areas indicated, clearly and legibly printing all information. Begin all entries from the left side of each field except where noted. Please note that the Iron Mountain systems do not recognize leading zeros in the **DIVISION ID**, **DEPARTMENT ID**, and **RECORD CODE** fields. For example, Department 0001234 would be recognized as Department 1234.



❶ Complete the ***Transmittal Sheet*** by printing:

a. Your four- or five-digit **CUSTOMER ID** on both the ***Transmittal Sheet and*** large peel-off ***Barcode Label*** (this is a must).

b. Your **CUSTOMER NAME**.

c. The **DIVISION ID*** of the **DEPARTMENT**, using up to 12 alphanumeric characters.
***NOTE:** Only customers specifically setup to use Divisions should utilize the **DIVISION** field.

d. The **DEPARTMENT ID** of the new cartons, using up to 10 alphanumeric characters*.
***NOTE:** Only customers specifically setup to use extended Department IDs should use blocks 11 and 12.

e. The **CUSTOMER BOX NUMBER** for each carton. This field should only be completed if you specifically assign a carton number other than the **SafeKeeperPLUS (SKP) BARCODE NUMBER** for your internal tracking purposes.

f. The **RECORD CODE** using up to 6 alphanumeric characters*.
***NOTE:** Only customers specifically setup to use extended Record Codes should use blocks 7 through 10. If the **RECORD CODE** parameter is set to '1' or '2', then anything in the **DESTROY DATE** or **DESTRUCTION INDICATOR** will be ignored by the system and overridden by the **RECORD CODE** rules. Only if the parameter is set to '0' or '3', will the system consider these values.

g. The **DATE RANGE/FROM** and **DATE RANGE/TO**, which are the oldest and most recent dates of the records contained in the carton. Retention can be calculated from these dates. Only valid dates including month, day and year are acceptable here.

h. The **ALPHA/NUMERIC RANGE-FROM** and **ALPHA/NUMERIC RANGE-TO**, which are the beginning and ending alphabetical/numerical ranges of the records contained in the carton. The FROM and TO Alpha/Numeric Range fields can be used to describe a name range (Jones through Smith), a numeric "file id" range (20450 through 20567), or an alphanumeric "file id" range (AD123 through BZ784).

i. The **CREATE DATE**, which is the date that the materials were packaged and labeled for storage; or, the date that the records were actually created. Retention can be calculated from these dates. Only a valid date including month, day and year is acceptable here.

j. The **EVENT DATE**, which is the date of the event that the contents of the carton contains, if applicable. Retention can be calculated from this date. Only a valid date including month, day and year is acceptable here.

k. The **DESTRUCTION ELIGIBILITY**, identifies when a carton is scheduled for destruction. Leave this section blank, if your organization establishes **DESTRUCTION ELIGIBILITY** using **RECORD CODES**. If your organization does not use **RECORD CODES** to determine when a carton is eligible for destruction, enter either a valid **Destruction Date**, (month/day/year) or check one of the **DESTRUCTION INDICATORS**: **Permanent** or **Undefined**.
NOTE: Nothing will be destroyed automatically. A letter of authorization from your organization is required for destruction.

l. The **HOLD CODE** for each carton, extends the **RETENTION PERIOD** of a carton. **HOLD CODES** must be setup on the system prior to use. If records should be retained permanently, select the check box under **DESTRUCTION ELIGIBILITY**.

m. The **MAJOR DESCRIPTION** of the contents of the carton as it is to appear on the ***Inventory Reports*** provided by Iron Mountain.

Example: ALE - AMA or 100 - 999 (numeric or alpha ranges must be separated with a dash).

Example: CORRESPONDENCE (complete descriptions may be spelled out).
NOTE: To keep numeric ranges in the proper sort sequence and to maintain an orderly listing, the dash '-' should be placed to the right of the heavy vertical line; fields should be zero-filled where necessary.

```
| | | |0|0|1|2|5|-|0|0|1|8|5| | | | |
| | | |1|2|0|5|0|-|1|2|1|7|5| | | | |
```

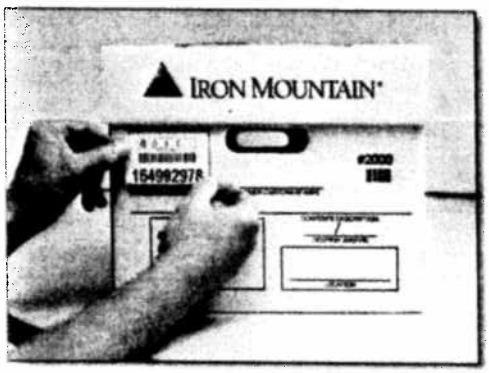
If the files within the carton will be individually listed, print the phrase "Individual List" in the **MAJOR DESCRIPTION** field. If you have previously filled out a ***Division/Department Form***, clearly establishing **RECORD CODES** for each **RECORD CODE TITLE**, then a **MAJOR DESCRIPTION** is not necessary.

n. Print additional **MINOR DESCRIPTION** information as it is to appear on your ***Inventory Reports*** (follow the instructions for **MAJOR DESCRIPTION**).

o. The **REFERENCE #1** field, which is a miscellaneous, alphanumeric field used for additional cross-reference information about the carton.

p. Your name in the **PREPARER'S FULL NAME** field, as well as the **DATE**, your **DIVISION ID**, **DEPARTMENT ID**, **TELEPHONE NUMBER** and **EXTENSION**, and **FLOOR**. At the top of the ***Sheet***, be sure to number the pages in sequence, starting with "Page 1".

❷ Place the large peel-off ***Barcode Label*** on the carton's *InfoPanel* in the area marked 'Affix Transmittal Label Here' on one of the handhold sides. Make sure your Customer ID is also displayed on the ***Label***.



Place the smaller, identically numbered ***Barcode Label*** on the ***Transmittal Sheet*** in the area marked 'Place the SafeKeeperPLUS® Barcode Label (T-Label) Here'.

❸ Once you have completed all of the ***Transmittal Sheets*** for this group of cartons you are sending, count the total number of ***Sheets*** and place this total number on all of the ***Sheets*** in the space marked "Page ____ of ____". Staple the ***Sheets*** together, in order.

❹ Have the **originals** ready for the driver to pick up with the new cartons. Make photocopies of the ***Transmittal Sheets*** for your records.

❺ Verify that the physical carton count matches the itemization on the ***Transmittal Sheets***.

❻ Contact Iron Mountain to schedule a pickup.

***NOTE:** To ensure the accuracy and integrity of your inventory requirements, please review all information listed on the transmittal document to ensure it is complete, accurate and legible, and the document has not been folded or torn before it is submitted to Iron Mountain.

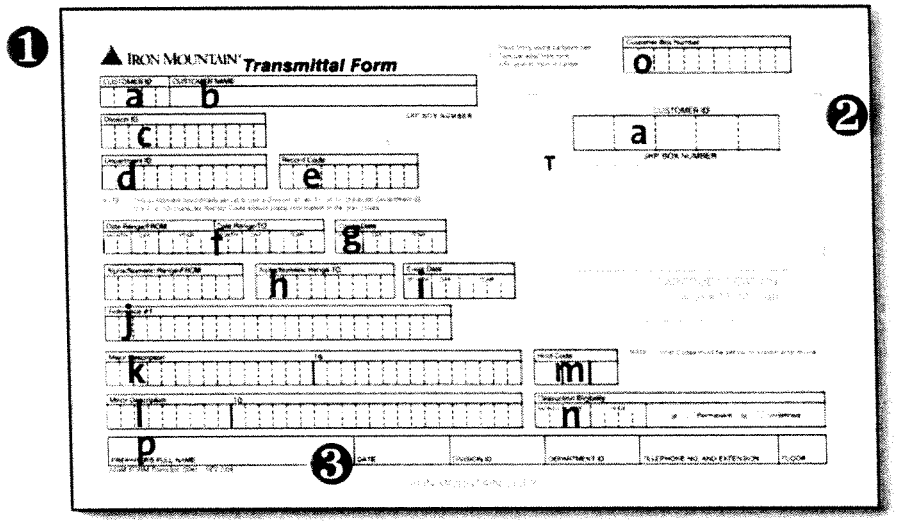
For detailed information about placing orders with Iron Mountain, refer to the Placing Requests and Orders *section of this* ***Handbook***.

The Transmittal Form

As an alternative to the ***Transmittal Sheet***, Iron Mountain also offers the three-ply ***Transmittal Form***, which allows you to provide all of the information required to properly index your records **one** carton at a time.

Completing the Transmittal Form

Complete one ***Transmittal Form*** for **each** new carton to be stored at Iron Mountain. Enter the correct information in the areas indicated, clearly and legibly printing all information. Begin all entries from the left side of each field. Please note that the Iron Mountain systems do not recognize leading zeros in the **DIVISION ID**, **DEPARTMENT ID**, and **RECORD CODE** fields. For example, Department 0001234 would be recognized as Department 1234.



❶ Complete the ***Transmittal Form*** by printing:

a. Your four- or five-digit **CUSTOMER ID** on both the ***Transmittal Form and*** the peel-off ***Barcode Label*** (this is a must).

b. Your **CUSTOMER NAME**.

c. The **DIVISION ID*** of the **DEPARTMENT**, using up to 12 alphanumeric characters.
***NOTE:** Only customers specifically setup to use Divisions should utilize the **DIVISION** field.

d. The **DEPARTMENT ID** of the new carton, using up to 10 alphanumeric characters*.
***NOTE:** Only customers specifically setup to use extended Department IDs should use blocks 11 and 12.

e. The **RECORD CODE** using up to 6 alphanumeric characters*.
***NOTE:** Only customers specifically setup to use extended Record Codes should use blocks 7 through 10. If the **RECORD CODE** parameter is set to '1' or '2', then anything in the **DESTROY DATE** or **DESTRUCTION INDICATOR** will be ignored by the system and overridden by the **RECORD CODE** rules. Only if the parameter is set to '0' or '3', will the system consider these values.

f. The **DATE RANGE/FROM** and **DATE RANGE/TO**, which are the oldest and most recent dates of the records contained in the carton. Retention can be calculated from these dates. Only valid dates including month, day and year are acceptable here.

g. The **CREATE DATE**, which is the date that the materials were packaged and labeled for storage; or, the date that the records were actually created. Retention can be calculated from these dates. Only a valid date including month, day and year is acceptable here.

h. The **ALPHA/NUMERIC RANGE-FROM** and **ALPHA/NUMERIC RANGE-TO**, which are the beginning and ending alphabetical/numerical ranges of the records contained within the carton. The FROM and TO Alpha/Numeric Range fields can be used to describe a name range (Jones through Smith), a numeric "file id" range (20450 through 20567), or an alphanumeric "file id" range (AD123 through BZ784).

i. The **EVENT DATE**, which is the date of the event that the contents of the carton contains, if applicable. Retention can be calculated from this date. Only a valid date including month, day and year is acceptable here.

j. The **REFERENCE #1** field, which is a miscellaneous, alphanumeric field used for additional cross-reference information about the carton.

k. The **MAJOR DESCRIPTION** of the contents of the carton as it is to appear on the ***Inventory Reports*** provided by Iron Mountain.

Example: ALE - AMA or 100 - 999 (numeric or alpha ranges must be separated with a dash).

Example: CORRESPONDENCE (complete descriptions may be spelled out).
NOTE: To keep numeric ranges in the proper sort sequence and to maintain an orderly listing, the dash '-' should be placed to the right of the heavy vertical line; fields should be zero-filled where necessary.

```
| | | |0|0|1|2|5|-|0|0|1|8|5| | | | |
| | | |1|2|0|5|0|-|1|2|1|7|5| | | | |
```

If the files within the carton will be individually listed, print the phrase "Individual List" in the **MAJOR DESCRIPTION** field. If you have previously filled out a ***Division/Department Form***, clearly establishing **RECORD CODES** for each **RECORD CODE TITLE**, then a **MAJOR DESCRIPTION** is not necessary.

l. Print additional **MINOR DESCRIPTION** information as it is to appear on your ***Inventory Reports*** (follow the instructions for **MAJOR DESCRIPTION**).

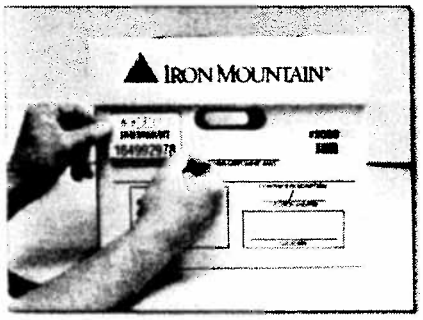
m. The **HOLD CODE** for each carton, extends the **RETENTION PERIOD** of a carton. **HOLD CODES** must be setup on the system prior to use. If records should be retained permanently, select the check box under **DESTRUCTION ELIGIBILITY**.

n. The **DESTRUCTION ELIGIBILITY**, identifies when a carton is scheduled for destruction. Leave this section blank, if your organization establishes **DESTRUCTION ELIGIBILITY** using **RECORD CODES**. If your organization does not use **RECORD CODES** to determine when a carton is eligible for destruction, enter either a valid **Destruction Date**, (month/day/year) or check one of the **DESTRUCTION INDICATORS**: **Permanent** or **Undefined**.
NOTE: Nothing will be destroyed automatically. A letter of authorization from your organization is required for destruction.

o. The **CUSTOMER BOX NUMBER** for each carton. This field should only be completed if you specifically assign a carton number other than the **SafeKeeperPLUS (SKP) BARCODE NUMBER** for your internal tracking purposes.

p. Your name in the **PREPARER'S FULL NAME** field, as well as the **DATE**, your **DIVISION ID**, **DEPARTMENT ID**, **TELEPHONE NUMBER** and **EXTENSION**, and **FLOOR**.

❷ Place the peel-off ***Barcode Label*** from the ***Transmittal Form*** on the carton's *InfoPanel* in the area marked 'Affix Transmittal Label Here' on one of the handhold sides. Make sure your Customer ID is also displayed on the ***Label***.



❸ Place the pink copy of the ***Transmittal Form*** inside the carton on top of the files underneath the lid;
Retain the yellow copy for your records; and,
Present the white copy to the Iron Mountain driver along with the new cartons to be picked up.

❹ Verify that the physical carton count matches the quantity of white copies of the ***Transmittal Form***.

❺ Contact Iron Mountain to schedule a pickup.

For detailed information about placing orders with Iron Mountain, refer to the Placing Requests and Orders *section of this* ***Handbook***.

Individually Listing Your Files

*Some Customers elect to catalogue **file-level** information such as file name and/or file number for each file within a carton. This process is called **Individually Listing** your files.*

*Iron Mountain **File Listing Input Sheets** are designed to help you list the files within a carton in a logical and orderly fashion and are available based on your type of business:*

- *The green **Standard File Listing Input Sheet**, generic enough for most organizations*
- *The **brown Law File Listing Input Sheet** for law firms and those in the legal profession*

*File-level descriptive information entered on the **Standard** or **Law File Listing Input Sheets** will subsequently appear on the **File Inventory** and **File Supplemental Reports** produced by Iron Mountain. Although individual files can be retrieved regardless of whether or not they have been Individually Listed, a complete file-level inventory report is a valuable tool because it provides full and accurate information about each file at a micro level. The individual files and all of the information about them are then available online as you place orders.*

Iron Mountain can help you with the maintenance of your professional records management program by individually listing the contents of each carton that you send to us. Contact your Iron Mountain Account Manager for more information.

Individually Listing is a Two-step Process

When you make the decision to Individually List your files, you will need to complete a ***Transmittal Sheet*** in order to capture the *carton-level* information, as well as a ***File Listing Input Sheet*** to capture the *file-level* descriptive information.

Completing the Transmittal Sheet

For each carton of files to be individually listed:

1. Include all pertinent carton information on the ***Transmittal Sheet***, including the Iron Mountain **CUSTOMER ID** and **DESTRUCTION ELIGIBILITY**. Additionally, the phrase "Individual List" should be written in the **MAJOR DESCRIPTION** field.

2. For each carton that contains files to be individually listed: Place the large peel-off ***green-bordered Barcode Label*** (i.e., Green T-Label) on the carton's *InfoPanel* in the area marked 'Affix Transmittal Label Here' on one of the handhold sides. Make sure your Customer ID is also displayed on the Label. Place the smaller, identically numbered ***green-bordered Barcode Label*** on the ***Transmittal Sheet*** in the area marked 'Place the SafeKeeperPLUS® Barcode Label (T-Label) Here'.

   The green border on the ***Barcode Label*** alerts Iron Mountain Data Entry that the contents of the carton should be individually listed.

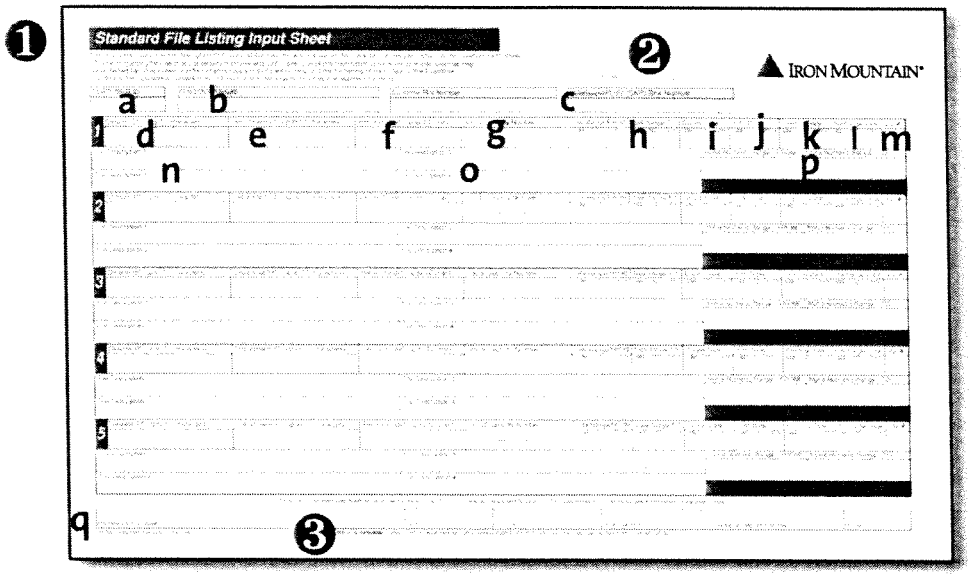
Completing the File Listing Input Sheet

Complete the appropriate ***File Listing Input Sheet*** for each carton of files that you would like to have individually listed. Multiple ***File Listing Input Sheets*** may be needed to list all of the files within a particular carton. Always begin with a new ***File Listing Input Sheet*** when describing a new carton of records.

As with the ***Transmittal Sheet***, information that is data entered from the ***Standard*** or ***Law File Listing Input Sheets*** is provided back to you via inventory reports generated by Iron Mountain.

The Standard File Listing Input Sheet

Use the green ***Standard File Listing Input Sheet*** for virtually any type of business and file type.



❶ Complete the ***Standard File Listing Input Sheet*** by printing:

- **a.** Your four- or five-digit **CUSTOMER ID**.
- **b.** Your **CUSTOMER NAME**.
- **c.** The **CUSTOMER BOX NUMBER** (provided that you assign your own carton numbers) and **SafeKeeperPLUS (SKP) BARCODE NUMBER** of the files listed on this ***Sheet***.
- **d.** The **DIVISION ID*** of the **DEPARTMENT**, using up to 12 alphanumeric characters.
  ***NOTE:** Only customers specifically setup to use Divisions should utilize the **DIVISION** field.
- **e.** The **DEPARTMENT ID** of the file, using up to 10 alphanumeric characters*.
  ***NOTE:** Only customers specifically setup to use extended Department IDs should use blocks 11 and 12.
- **f.** The **RECORD CODE**, using up to 6 alphanumeric characters*. This information should match the ***Transmittal Sheet***.
  ***NOTE:** Only customers specifically setup to use extended Record Codes should use blocks 7 through 10.
- **g.** The **SOCIAL SECURITY NUMBER**** of the individual on this file, if applicable.
  NOTE: Use of social security numbers in California may be prohibited. Iron Mountain recommends that Customers in California, who wish to include social security numbers, first consult with their Legal Counsel.
- **h.** The **DATE RANGE/FROM** and **DATE RANGE/TO**, which are the oldest and most recent dates of this file. Only valid dates including month, day and year are acceptable here.
- **i.** The **CREATE DATE**, which is the date that the file was packaged and labeled for storage; or, the date that the file was actually created. Only a valid date including month, day and year is acceptable here.
- **j.** The **BIRTH DATE**** of the individual on this file, if applicable. Only a valid date including month, day and year is acceptable here.
- **k.** The **DESTROY DATE**, which is the date that the file should be reviewed for destruction. Only a valid date including month, day and year is acceptable here. This information should match the ***Transmittal Sheet***; check PERM if the file is to be retained Permanently.
- **l.** The **DISCHARGE DATE**, which is the date that the individual on this file was released from care, if applicable. Only a valid date including month, day and year is acceptable here.

m. The **VOL#** [Volume Number], which is a quantity of files that makes up one file unit.

n. The description(s) of each file, using **FILE DESCRIPTION 1** and **FILE DESCRIPTION 2**.

o. Additional descriptions of each file, using **FILE DESCRIPTION 3** and **FILE DESCRIPTION 4**.

p. The **ALPHA/NUMERIC RANGE-FROM** and **ALPHA/NUMERIC RANGE-TO**, which are the beginning and ending alphabetical/numerical ranges of the records contained within the carton. The FROM and TO Alpha/Numeric Range fields can be used to describe a name range (Jones through Smith), a numeric "file id" range (20450 through 20567), or an alphanumeric "file id" range (AD123 through BZ784). This information should match the ***Transmittal Sheet***.

q. Your name in the **PREPARER'S FULL NAME** field, as well as the **DATE**, your **DIVISION ID**, **DEPARTMENT ID**, **TELEPHONE NUMBER** and **EXTENSION**, and **FLOOR**.

****NOTE:** Regarding the use of social security numbers and birth dates: Use of these fields constitutes personal data that may be protected by privacy laws. Iron Mountain is happy to include this data, and the furnishing of such data by the Customer constitutes the Customer's consent to its inclusion on Iron Mountain's inventory management systems.

❷ Once you have completed all of the ***Standard File Listing Input Sheets*** for this group of files you are individually listing, count the total number of ***Sheets*** and place this total number on all of the ***Sheets*** in the space marked "Page ____ of ____." Staple the ***Sheets*** together, in order.

❸ Have the **originals** ready for the driver to pickup with the new cartons. Make photocopies of the ***Standard File Listing Input Sheets*** for your records.

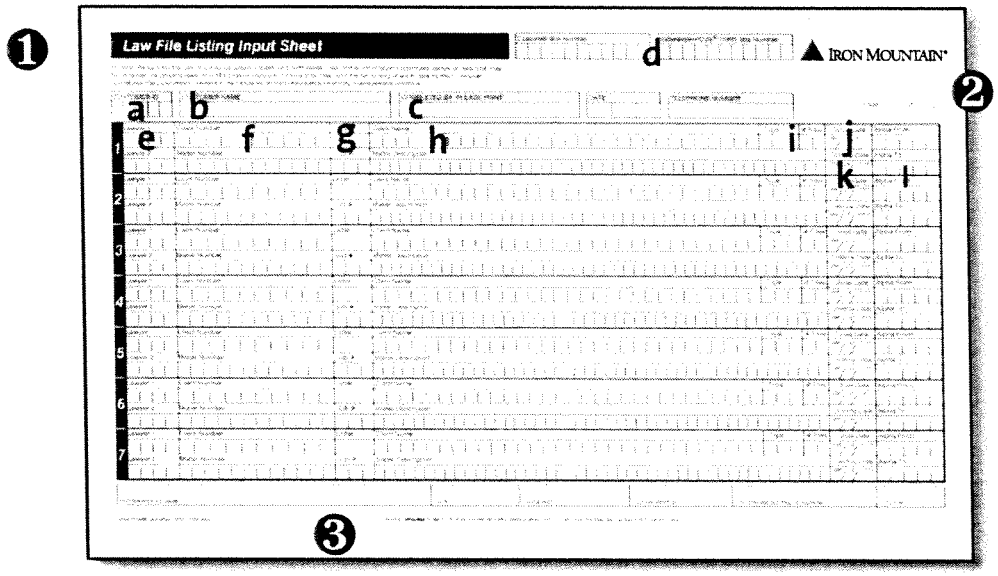
❹ Verify that the physical file count matches the itemization on the ***Standard File Listing Input Sheets***.

❺ Contact Iron Mountain to schedule a pickup.

For detailed information about placing orders with Iron Mountain, refer to the Placing Requests and Orders *section of this* ***Handbook***.

The Law File Listing Input Sheet

The ***Law File Listing Input Sheet*** is tailored specifically for those in law firms and the legal profession. If your company's files are maintained in Iron Mountain's LAW format, then use the brown ***Law File Listing Input Sheet*** for listing individual legal file information.



❶ Complete the ***Law File Listing Input Sheet*** by printing:

- **a.** Your four- or five-digit **CUSTOMER ID**.
- **b.** Your **CUSTOMER NAME**.
- **c.** Your name in the **COMPLETED BY** field, as well as the **DATE** and your **TELEPHONE NUMBER** and **EXTENSION**.
- **d.** The **CUSTOMER BOX NUMBER** (provided that you assign your own carton numbers) and **SafeKeeperPLUS (SKP) BARCODE NUMBER** of the files listed on this ***Sheet***.
- **e.** The initials of as many as two contributors to this file in the **LAWYER 1** and **LAWYER 2** fields.
- **f.** The **CLIENT NUMBER** and **MATTER NUMBER** that correspond to this file.
- **g.** Use the **LETTER** and **SUB NUMBER** fields as you desire.
- **h.** The **CLIENT NAME** and **MATTER DESCRIPTION** of this file.
- **i.** Use the **TYPE** and **# FILES** as you desire.
- **j.** The **CLOSE DATE** of this file. Only a valid date including month, day and year is acceptable here.
- **k.** The **DESTROY DATE**, which is the date that the file should be reviewed for destruction. Only a valid date including month, day and year is acceptable here. This information should match the ***Transmittal Sheet***; check PERM if the file is to be retained Permanently.
- **l.** The **ALPHA/NUMERIC RANGE-FROM** and **ALPHA/NUMERIC RANGE-TO**, which are the beginning and ending alphabetical/numerical ranges of the files within the carton in which this file is stored. The FROM and TO Alpha/Numeric Range fields can be used to describe a name range (Jones through Smith), a numeric "file id" range (20450 through 20567), or an alphanumeric "file id" range (AD123 through BZ784). This information should match the ***Transmittal Sheet***.

**NOTE: Regarding the use of social security numbers and birth dates: Use of these fields constitutes personal data that may be protected by privacy laws. Iron Mountain is happy to include this data, and the furnishing of such data by the Customer constitutes the Customer's consent to its inclusion on Iron Mountain's inventory management systems.

❷ Once you have completed all of the ***Law File Listing Input Sheets*** for this group of files you are individually listing, count the total number of ***Sheets*** and place this total number on all of the ***Sheets*** in the space marked "Page _____ of _____." Staple the ***Sheets*** together, in order.

❸ Have the **originals** ready for the driver to pickup with the new cartons. Make photocopies of the ***Law File Listing Input Sheets*** for your records.

❹ Verify that the physical file count matches the itemization on the ***Law File Listing Input Sheets***.

❺ Contact Iron Mountain to schedule a pickup.

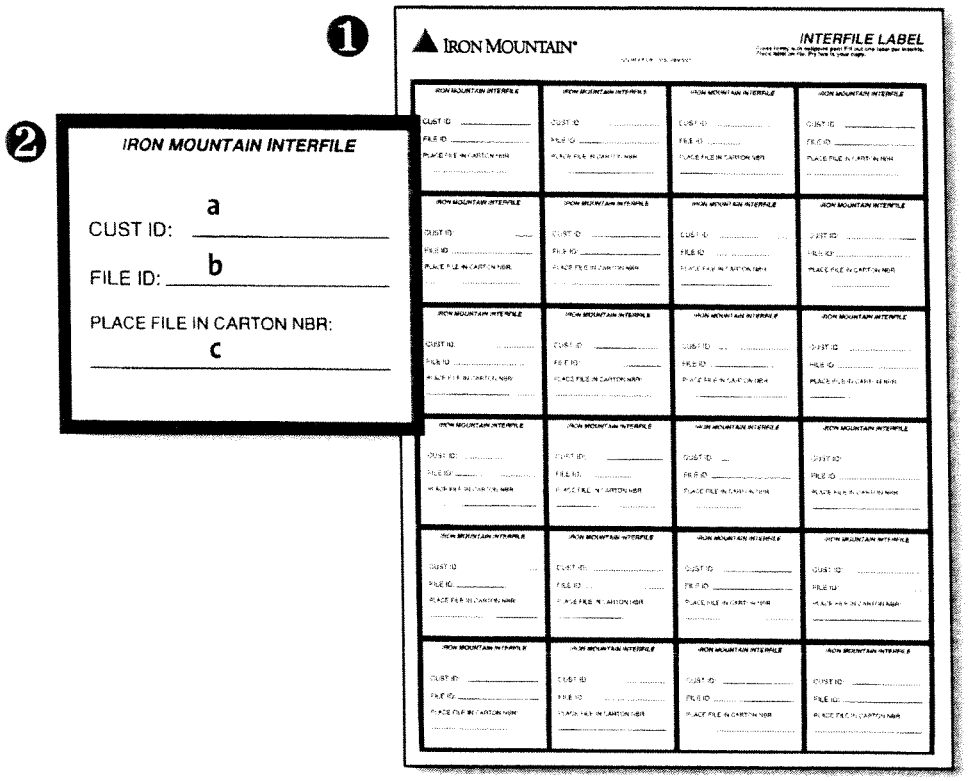
For detailed information about placing orders with Iron Mountain, refer to the Placing Requests and Orders *section of this* ***Handbook***.

Sending Interfiles to Iron Mountain

*An **interfile** is defined as a file to be placed within an existing carton, or on an open file shelf, at Iron Mountain. In order to provide accurate tracking and documentation, an **Interfile Label** must be applied to each interfile being sent to storage at Iron Mountain.*

Completing the Interfile Label

A blue ***Interfile Label*** is applied to a **new** *individual file* to be placed within a *carton*, or on an open file shelf, at Iron Mountain. Complete one ***Interfile Label*** for **each** file to be interfiled. Insert the correct information in the areas indicated, clearly and legibly printing all information.



❶ Complete the ***Interfile Label*** by printing:

- **a.** Your four- or five-digit **CUSTOMER ID**.
- **b.** The **FILE ID** or **FILE DESCRIPTION** of the file to be interfiled.
- **c.** The **CUSTOMER BOX NUMBER** (provided that you assign your own carton numbers) or **SafeKeeperPLUS (SKP) BARCODE NUMBER** of the carton in which this *interfile* should be filed.

❷ Place the ***Interfile Label*** on the *file*, retaining the carbon for your reference.

❸ Contact Iron Mountain to schedule a pickup.

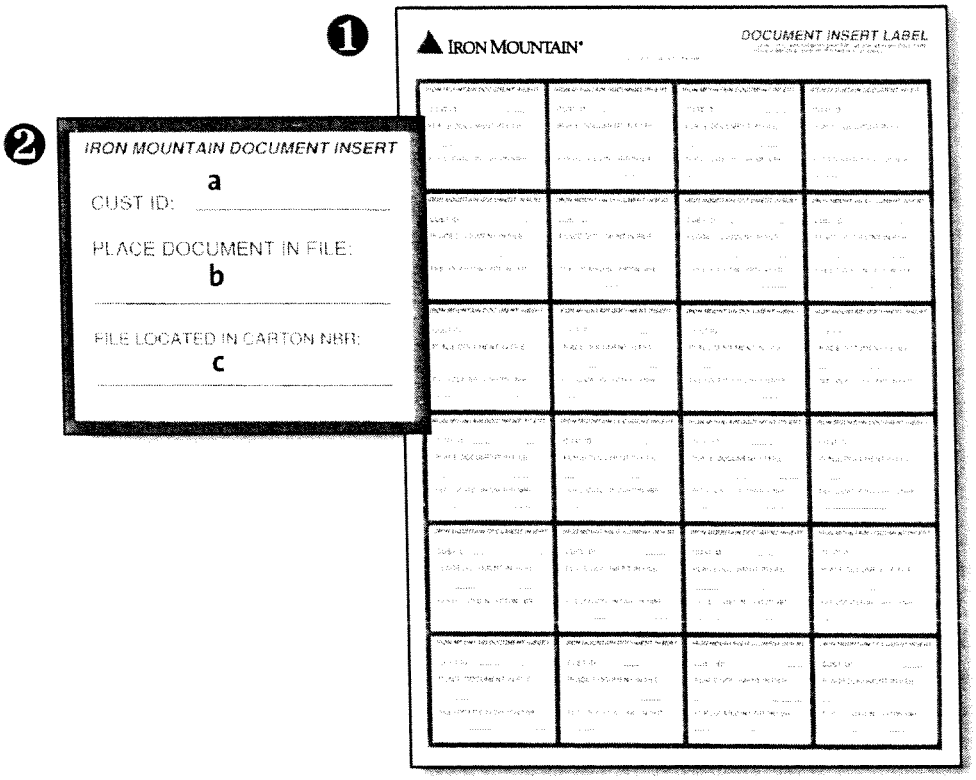
For detailed information about placing orders with Iron Mountain, refer to the Placing Requests and Orders *section of this **Handbook**.*

Sending Document Inserts to Iron Mountain

*A **document insert** is defined as a document to be placed within an existing file, or on an open file shelf, at Iron Mountain. In order to provide accurate tracking and documentation, a **Document Insert Label** must be applied to each document insert being sent to storage at Iron Mountain.*

Completing the Document Insert Label

A red ***Document Insert Label*** is applied to a **new** *document* to be inserted inside a *file* within a *carton*, or on an open file shelf, at Iron Mountain. Complete one ***Document Insert Label*** for **each** *document* to be interfiled. Insert the correct information in the areas indicated, clearly and legibly printing all information.



❶ Complete the ***Document Insert Label*** by printing:

- **a.** Your four- or five-digit **CUSTOMER ID**.
- **b.** The **FILE NAME** or **FILE NBR** of the file in which this *document* is to be interfiled.
- **c.** The **CUSTOMER BOX NUMBER** (provided that you assign your own carton numbers) or **SafeKeeperPLUS (SKP) BARCODE NUMBER** of the carton where the *file* is located in which this *document* should be interfiled.

❷ Place the ***Document Insert Label*** on the *document*, retaining the carbon for your reference.

❸ Contact Iron Mountain to schedule a pickup.

For detailed information about placing orders with Iron Mountain, refer to the Placing Requests and Orders *section of this **Handbook**.*

Returning Previously Retrieved Records Back to Storage at Iron Mountain

In order to maintain a well-controlled records management program, the timely return of previously retrieved items to the record center is critical.

Outcards are created and retained for individual files that have been retrieved from storage. Retrieval information is kept as history on both the Outcard and Iron Mountain's systems. This information is then automatically updated upon the return and subsequent barcode scanning of the items back into storage and, ultimately, to their shelf locations.

Returning Records to Storage

Returning previously retrieved records to storage at Iron Mountain is a three-step process:

❶ For ease of counting later on, **separate the records** you are returning to storage into

- ***Individual Files***
- ***Entire Cartons***
- ***Tapes/Vital records***
- ***Interfiles***
  - Files
  - Documents

❷ **Count** how many of each item you have. For *Entire Carton* refiles, please note how many there are of each carton model [size].

Example: There are 10 entire carton refiles: five are letter/legal model #2000, and five are legal transfer model #550. Knowing the carton model numbers helps determine each carton's cubic footage, which helps Iron Mountain schedule an appropriately sized vehicle to pickup your records.

For *Individual File Refiles*, please specify the quantity of **files** and **individual documents**.

❸ **Contact Iron Mountain** to schedule a pickup.

For detailed information about placing orders with Iron Mountain, refer to the Placing Requests and Orders *section of this* ***Handbook.***

Periodic and Special Reporting

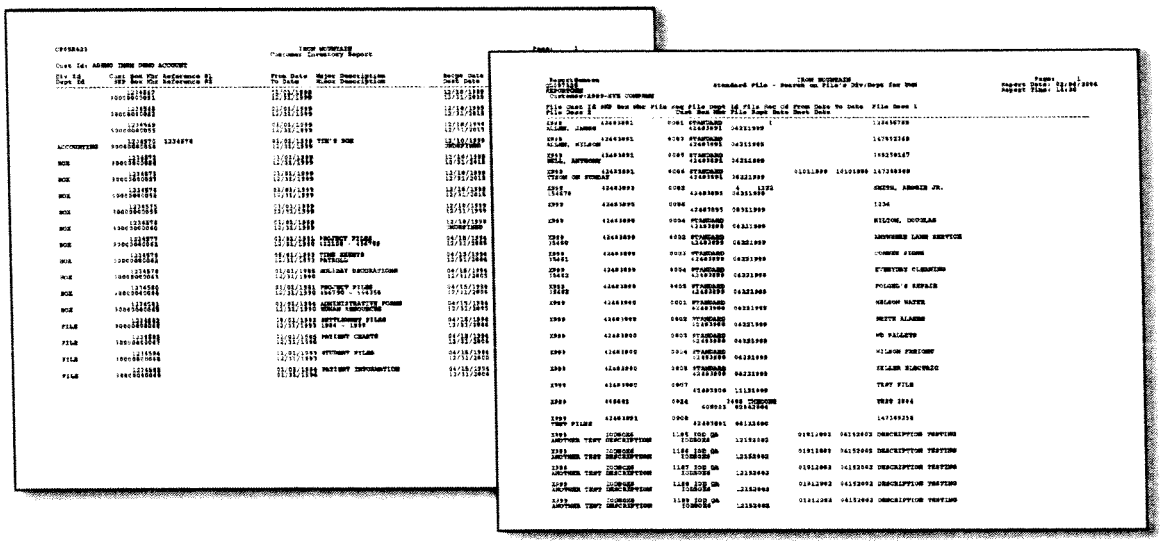
Detailed reports are provided to you by Iron Mountain for your use in tracking and managing your records management program. All reporting is available in an 8.5" x 11" laser-printed format for your convenience, or, if you wish, in a number of electronic transmission formats such as the Iron Mountain Connect records management portal, e-mail, electronic file transfer, or CD-ROM.

The Inventory Report

Iron Mountain generates an ***Inventory Report*** that may be printed at the anniversary of your agreement with Iron Mountain and sent to you for your review.

Standard informational fields provided in this report include:
DIVISION ID, **DEPARTMENT ID**, **RECORD CODE**, **FROM DATE**, **TO DATE**, **MAJOR DESCRIPTION**, **MINOR DESCRIPTION**, **CUSTOMER BOX NUMBER**, **RECEIPT DATE**, **DESTROY DATE**, **SafeKeeperPLUS (SKP) BARCODE NUMBER**, **CUBIC FOOTAGE**, **STATUS**.

All inventory is automatically sorted in the following manner (unless you have specifically requested a customized sort):
DIVISION ID, **DEPARTMENT ID**, **RECORD CODE**, **FROM DATE**, **TO DATE**, **MAJOR DESCRIPTION**, **MINOR DESCRIPTION**, **CUSTOMER BOX NUMBER**.



Using the Inventory Report

The ***Inventory Report*** is cumulative and represents all carton or individually listed file inventory that you currently maintain with Iron Mountain. All ***Supplemental Reports*** with a print date *prior to* the date of the ***Inventory Report*** should be discarded or filed for historical purposes.

Your most recent ***Inventory Report*** should be used in preparation for any service transaction with Iron Mountain. This includes, but is not limited to, retrievals, internal projects, permanent withdrawals, destruction, and carton-level inventory maintenance.

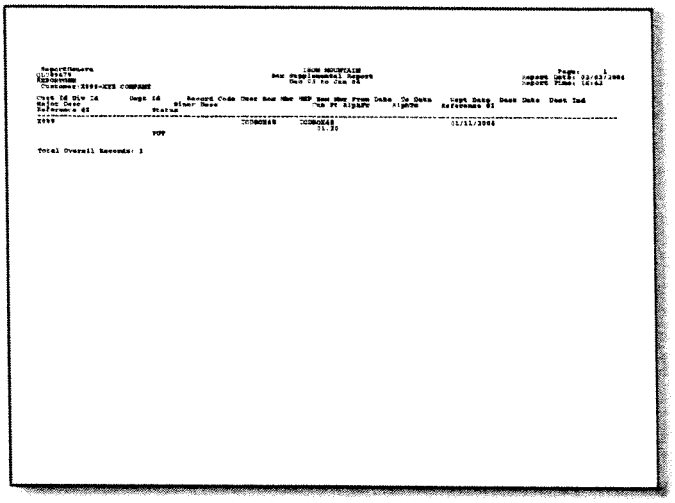
Simply access the inventory by finding the **DIVISION ID**, **DEPARTMENT ID**, and then the **RECORD CODE** of the carton or individually listed file you are researching, and scan across the page to review the inventory description.

The Supplemental Reports

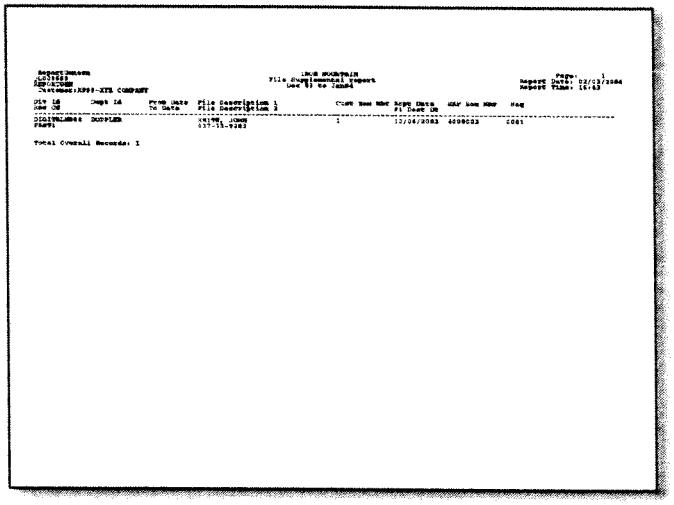
Supplemental Reports are additional reports that display new cartons and/or individually listed files that have been added to your inventory with Iron Mountain during the prior month. These reports may be generated monthly in order to provide timely updates to your ***Inventory Report*** and to act as a detail to your ***Invoice***. Information provided in these reports is typical of that provided in the ***Inventory Report***.

Using Your Supplemental Reports

There are three types of ***Supplemental Reports*** for your convenience: the ***Box Supplemental Report***, the ***File Supplemental Report***, and the ***Returned Records Report***. The title of each of the ***Supplemental Reports*** is clearly listed in the heading of each report.



The Box Supplemental Report. The ***Box Supplemental Report*** is a monthly recap of all *new cartons* that have been added to inventory at Iron Mountain during the prior month. If no new cartons were sent to storage in the prior month, then a ***Box Supplemental Report*** is not generated. This carton-level report, in conjunction with your most recent ***Inventory Report***, serves as an up-to-date record of your inventory with Iron Mountain. Copies of your ***Transmittals***, which you completed and retained for all new cartons sent to Iron Mountain during the month, can then be compared to the ***Box Supplemental Report*** and filed. The ***Box Supplemental Report*** becomes the formal record of these cartons on inventory with Iron Mountain.



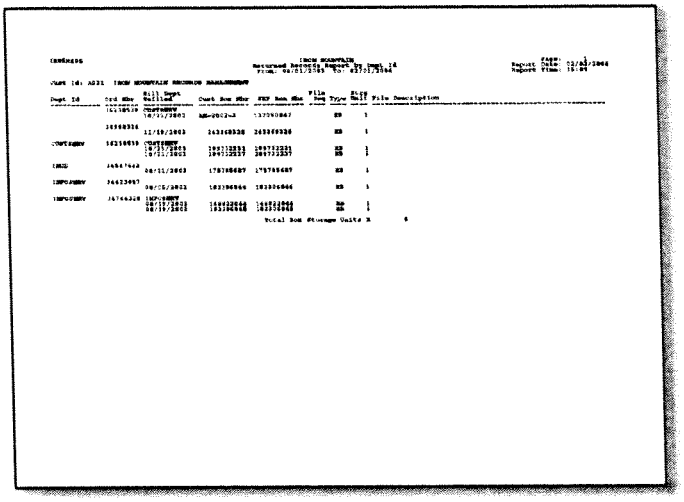
The File Supplemental Report. The ***File Supplemental Report*** is a monthly recap of all *new files* that have been individually listed and added to your inventory at Iron Mountain during the prior month. If no new files were individually listed in the prior month, then a ***File Supplemental Report*** is not generated. Similarly, if you do not individually list your files, a report is not generated for you. This file-level report works in conjunction with your most recent ***File Inventory Report*** and serves as an up-to-date record of your individually listed file inventory with Iron Mountain. Contact your Iron Mountain Account Manager for more information about having your files individually listed.

Use the ***File Supplemental Report*** to access individually listed files for placing retrieval orders with Iron Mountain. The carton number pertinent to each file is listed, so you can use either the **FILE DESCRIPTION** or the **FILE SEQUENCE NUMBER** to order it. To place your request in the most efficient way possible, use the combination of the **SafeKeeperPLUS Barcode ID** and the **FILE SEQUENCE NUMBER** when placing your order.

The ***File Supplemental Report*** automatically prints based on the industry file format of your files.

The Returned Records Report. The ***Returned Records Report*** includes Information about cartons and files that have been returned to Iron Mountain (i.e., refiled) during the prior month. The date range included on the report is clearly listed at the top of each page. All inventory refiled during the prior month is automatically sorted in the following manner:

PICKUP ORDER NUMBER and **BILL TO DEPT ID**, **REFILE DATE**, **DEPARTMENT ID** *from inventory*, **CUSTOMER BOX NUMBER**, **SafeKeeperPLUS (SKP) BARCODE NUMBER**, **FILE SEQUENCE NUMBER**, **REFILE TYPE** (EB: *Entire Carton* or IF: *Individual File*), and **FILE DESCRIPTION**.



The ***Returned Records Report*** is a monthly recap of all of your cartons and files that have been *refiled* at Iron Mountain during the prior month for the **DATE RANGE** specified. If no cartons or files were returned to Iron Mountain in the prior month, then a ***Returned Records Report*** is not generated.

The **ORDER NUMBER**, **REFILE DATE**, **DEPARTMENT ID** from the inventory record, **CUSTOMER BOX NUMBER**, **SafeKeeperPLUS (SKP) BARCODE NUMBER**, **FILE SEQUENCE NUMBER** (for Individual File refiles), **REFILE TYPE**, **STORAGE UNITS**, and **FILE DESCRIPTION** are all listed for your convenience.

You can review the ***Returned Records Report*** by **ORDER NUMBER** and **REFILE DATE**. The **TOTAL STORAGE UNITS** for both carton refiles and individual file refiles are listed at the end of the report and may be used for ***Invoice*** reconciliation.

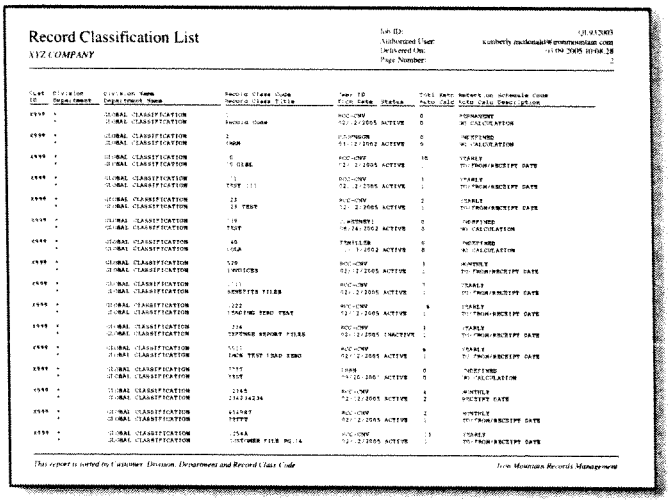
Management Reporting

In addition to the ***Supplemental Reports***, there are several management reports that are available to you through Iron Mountain. These reports will help you to:

- Manage your records program
- Maintain records retention schedules in records classification form
- Review cost allocations of your program for a designated time frame
- Prepare your records for destruction

The most commonly requested management reports are the ***Records Classification Report***, the ***Cost & Activity Report***, the ***Retrieval History Report***, and the ***Authorized Users Report***. Contact your Iron Mountain Account Manager for assistance in deciding which inventory and/or management reports are appropriate for your organization.

The Records Classification Report. The ***Records Classification Report*** displays the **DIVISION ID**, **DEPARTMENT IDs**, and **RECORD CODES** on file with Iron Mountain for your **CUSTOMER ID**. The report sorts by **DIVISION ID** and **DEPARTMENT ID**, listing the following: **DIVISION ID**, **DIVISION NAME**, **DEPARTMENT ID**, **DEPARTMENT NAME**, **RECORD CODE**, **RECORD CODE TITLE**, **TOTAL RETENTION**, **RETENTION SCHEDULE**, **AUTOCALCULATE CODE**, and **DIVISION/DEPARTMENT STATUS**. If **HOLD CODES** are used, the **HOLD CODE** and the **HOLD CODE DESCRIPTION** will also be shown.


Record Classification List
XYZ COMPANY

Job ID:
Authorized User:
Delivered On:
Page Number:

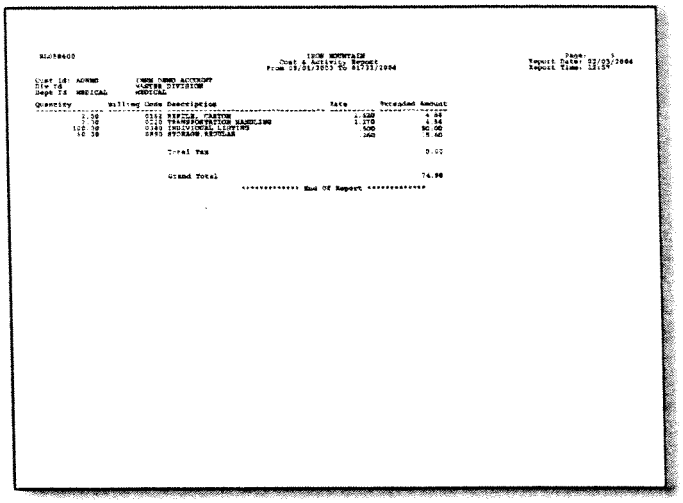
Cust ID	Division Department	Division Name Department Name	Record Class Code Record Class Title	User ID Rec Seq.	Status	Total Auto Calc	Retention Schedule Code Total Calc Description
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	0	PERMANENT
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	0	NO CALCULATION
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	0	UNDEFINED
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	0	NO CALCULATION
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	15	YEARLY
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]		TO FROM/RECEIPT DATE
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	1	YEARLY
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	1	TO FROM/RECEIPT DATE
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	2	YEARLY
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	1	TO FROM/RECEIPT DATE
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	0	UNDEFINED
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	0	NO CALCULATION
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	0	UNDEFINED
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	0	NO CALCULATION
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	3	MONTHLY
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	1	TO FROM/RECEIPT DATE
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	7	YEARLY
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	1	TO FROM/RECEIPT DATE
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	9	YEARLY
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	1	TO FROM/RECEIPT DATE
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	1	YEARLY
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	1	TO FROM/RECEIPT DATE
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	9	YEARLY
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	1	TO FROM/RECEIPT DATE
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	0	UNDEFINED
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	0	NO CALCULATION
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	4	MONTHLY
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	2	RECEIPT DATE
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	2	MONTHLY
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	1	TO FROM/RECEIPT DATE
[illegible]	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	13	YEARLY
	*	GLOBAL CLASSIFICATION	[illegible]	[illegible]	[illegible]	1	TO FROM/RECEIPT DATE

This report is sorted by Customer, Division, Department and Record Class Code — *Iron Mountain Records Management*

The **USER ID** of the person who last modified the **RECORD CODE** and the **RETENTION TRANSACTION DATE** of the last modification is also displayed.

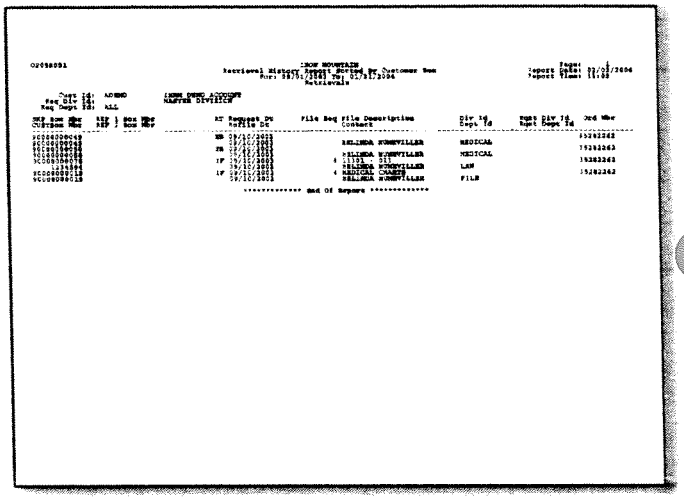
This report can be requested for one specific **DIVISION/DEPARTMENT ID** or for all **DIVISIONS** and/or **DEPARTMENT IDs**, with or without page breaks on the report.

The Cost & Activity Report. The ***Cost & Activity Report*** displays billing activity for a specified **DATE RANGE**. It can be used for cost allocation, as well as budget preparation or review. The **DATE RANGE** of the information included is clearly noted in the heading of the report.

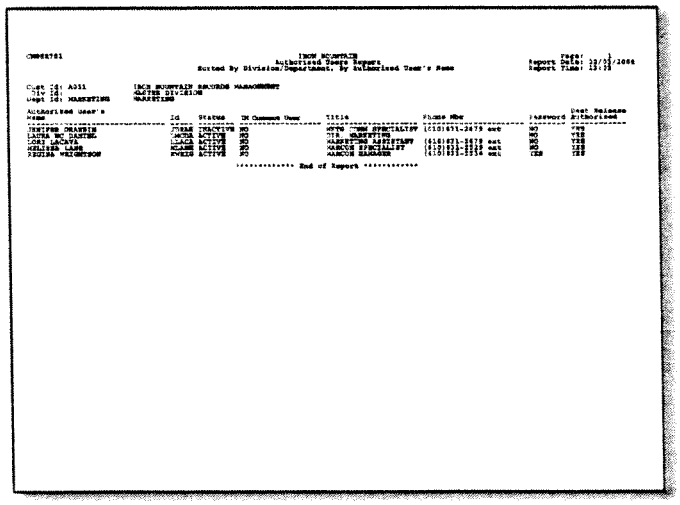


For the **DATE RANGE** specified, all billing transactions are totaled and the following fields are displayed: **QUANTITY**, **BILLCODE**, **BILLCODE DESCRIPTION**, **RATE**, **EXTENDED AMOUNT**, **SALES [TOTAL] TAX**, and **GRAND TOTAL**.

The Retrieval History Report. The ***Retrieval History Report*** displays the retrieval and refile activity history of cartons and files for a particular **DATE RANGE**. It can also be generated for inventory that has been permanently withdrawn or destroyed. The report sort and **DATE RANGE** of the activity history are identified in the report title, while the **CUSTOMER NAME** and **REQUESTING DIVISION** and/or **REQUESTING DEPARTMENT** titles are displayed in the report header.



Inventory matching the specified **DATE RANGE** and **STATUS OPTION** (OUT[carded], WTH[withdrawn], and DST [destroyed]) are displayed in the report body along with the: **SafeKeeperPLUS (SKP) BOX NUMBER** (barcode number), **CUSTOMER BOX NUMBER**, **REFERENCE 1 BOX NUMBER**, **REFERENCE 2 BOX NUMBER**, **TYPE** of inventory item requested: EB: *Entire Carton* or IF: *Individual File*, **REQUEST DATE**, **REFILE DATE**, **REFILE SEQ**[uence] Number, **FILE DESCRIPTION**, **CONTACT** person's name, **DIVISION ID** and **DEPT ID**, the **REQUESTING DIVISION ID**, **REQUESTING DEPT ID**, and the **ORDER NBR** on which the item was retrieved.



The Authorized Users Report. The ***Authorized Users Report*** lists the Authorized Users, representatives from your organization who are permitted to perform service transactions with Iron Mountain, for a particular **CUSTOMER ID** in the SafeKeeperPLUS system at a global, **DIVISION ID** or **DEPARTMENT ID** level. The report sort is identified in the report title, while the **CUSTOMER NAME** and **DIVISION** and/or **DEPARTMENT** titles are displayed in the report header.

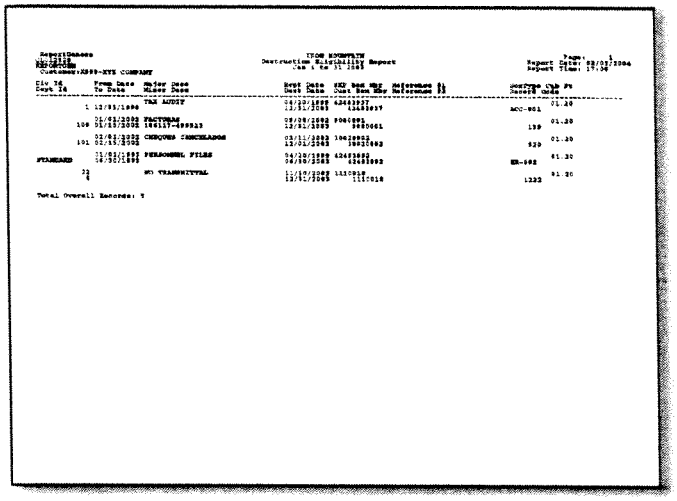
Authorized User **NAMES** are listed alphabetically in the report body along with the: **USER ID**, **STATUS** of the Authorized User (Active or Inactive), whether or not the Authorized User is also an Iron Mountain Connect user, the Authorized User's **TITLE** and **PHONE NUMBER**, whether or not a **PASSWORD** has been established (Yes/No) for that Authorized User (the actual password itself does not appear on the ***Authorized Users Report***, however), and a **DESTRUCTION RELEASE AUTHORIZED?** indicator (Yes/No).

Destruction Reporting

Other reports such as the ***Destruction Eligibility Report*** are also available to you by making a Special Request through Iron Mountain. Contact your Iron Mountain Account Manager for assistance with standard industry guidelines and in deciding which destruction criteria is best for your organization.

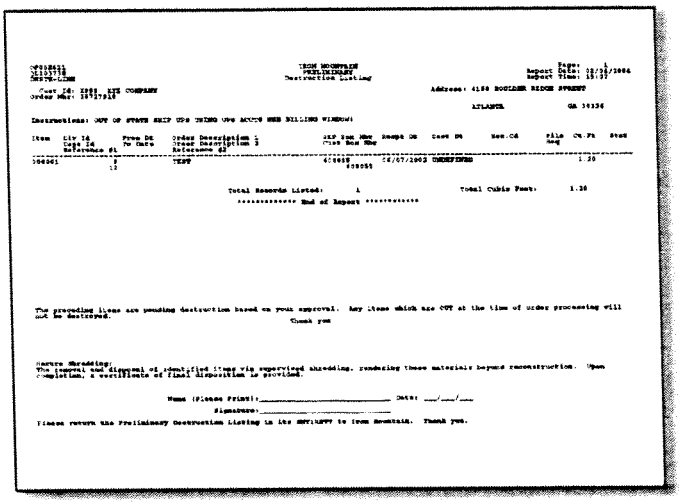
The Destruction Eligibility Report. The ***Destruction Eligibility Report*** is an inventory report which lists cartons and/or files that have a **DESTROY DATE** within a specified **DATE RANGE**. This report can be sorted several different ways based on your criteria, and is used primarily to identify those inventory items eligible to be destroyed. All or part of the report can be highlighted, signed by a Destruction Authorized User, and sent to Iron Mountain to initiate the destruction of inventory.

To facilitate your review, the full **INVENTORY DESCRIPTION** is displayed on the report.

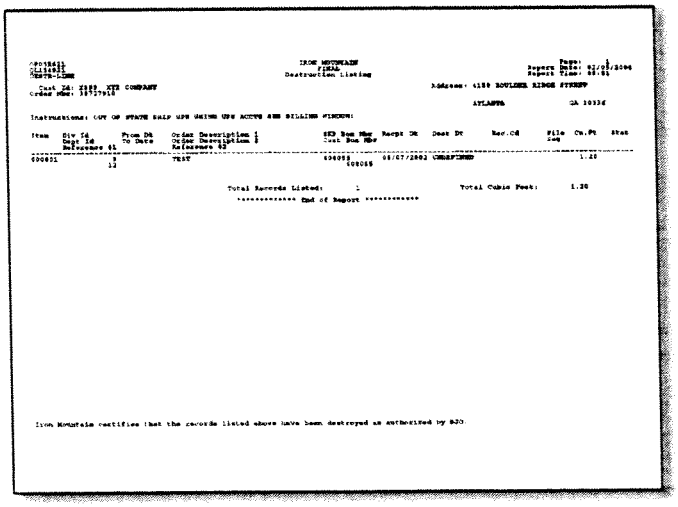


If you are confident that all of the cartons and/or individually listed files that match your **DESTROY DATE** criteria should be destroyed, you can request that a destruction order be created using a *span* of **DESTROY DATES**.

The Preliminary Destruction Listing. Upon receipt of your destruction request, Iron Mountain creates an order for the destruction of the cartons or files and automatically sends you a ***Preliminary Destruction Listing***, which reflects only those records that you previously identified as being eligible for destruction. Please review this ***Listing***, identify the appropriate destruction method — *recycling* or *secure shredding* — for each item, sign in the designated area and on the instructions letter, and return the ***Listing*** to Iron Mountain at the address clearly shown on the cover letter which accompanies it so that the destruction order may be processed. ***Iron Mountain will never destroy your inventory without the signed Preliminary Destruction Listing and instructions letter from a Destruction Authorized User in your organization.***



The Final Destruction Listing. After Iron Mountain receives your signed ***Preliminary Destruction Listing(s)*** and the destruction order is processed, a ***Final Destruction Listing*** is automatically generated and sent to you to verify that the destruction of your records, as you specified, has taken place. At that point, you will no longer pay storage for the destroyed inventory. Each record's descriptive information and retrieval history, however, will remain on the SafeKeeperPLUS system for future reference.



For detailed information about destroying records, refer to the Permanently Removing Records from Storage *section of this* ***Handbook***.

Special Reporting

Iron Mountain's standard inventory, management, and destruction reports described previously are suitable for the vast majority of our Customers. However, we recognize that you may have unique requirements, and report customization is available. Contact your Iron Mountain Account Manager for assistance in deciding which inventory and/or management reports are appropriate for your industry and business needs.

Account Access

Access to any of your information that is maintained by Iron Mountain is restricted to those who have been authorized, in writing, by your organization. In order to protect the security and confidentiality of your records management program, placing requests/orders and obtaining account information may only be placed by ***authorized individuals who are listed on the Authorized Users List.***

Authorized Access to Your Records

Your organization's representative(s) may be authorized to access cartons and files for an entire **CUSTOMER ID**, or if you choose, only for a specific **DIVISION ID** and/or **DEPARTMENT ID** within that **CUSTOMER ID**. To authorize individuals in your organization to access your records and information, complete an ***Access Authorization Form*** and fax or mail it to Iron Mountain.

IRON MOUNTAIN®

Access Authorization Form
Records Management

❑ ***New*** ❑ ***Update***

Customer Number/ID .....
Customer Name .....
Division ID .....
Department ID .....

Date ..... **Time** .....

❑ **All Divisions**
❑ **All Departments**

Strict Authorization will apply = *Only the names listed will have access to the account information*

Authorized Users ******Minimum of two authorized users required******
If the account is Department Restricted, a minimum of two authorized users is required for each Department ID

Authorized Contact Name (First Name / MI / Last Name)	Phone Number	Email Address	*Password (Optional)	DEPARTMENT (If department specific/restricted)	Authorized Destruction Please Circle
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO

*Password security is optional. Passwords can be any alphanumeric combination up to 10 characters.

Please fax or e-mail completed form to:

Authorized By .....
(above signature must be a currently authorized requestor)

Phone Number / Ext ( ) - ext.

Fax: **1-800 934-5348**
email: [illegible]@ironmountain.com

v.12.12.06

Establishing and Using Passwords

As an additional level of security, an individual **PASSWORD** can be established for each **AUTHORIZED USER**. This **PASSWORD** must be provided by the requestor prior to placing the order and is validated during the order entry process in the Iron Mountain systems. A "Password Given" message prints on the ***Packing Slip*** to confirm that the **PASSWORD** was provided. To establish the procedure of disallowing order processing unless the correct **PASSWORD** is provided by the **AUTHORIZED USER**, be sure to assign a **PASSWORD** for *each* **AUTHORIZED USER** on the ***Access Authorization Form***, as described above.

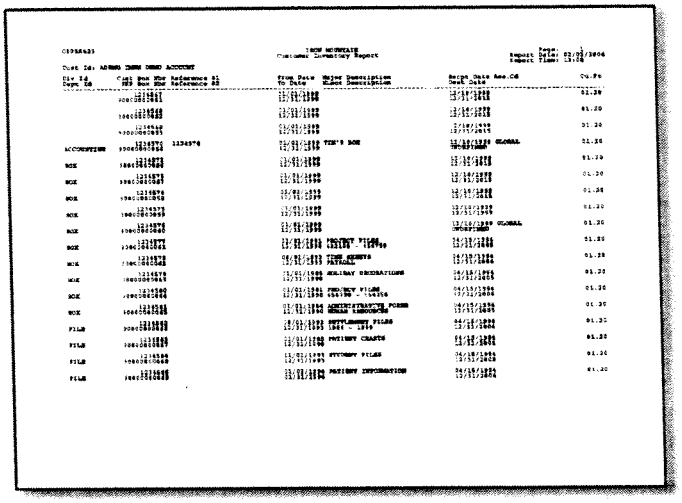
For more information about establishing Authorized Users, please contact your Iron Mountain Account Manager.

Locating Your Inventory

Placing orders with Iron Mountain Records Management is easy when you know your **SafeKeeperPLUS (SKP) BARCODE NUMBER** *and* **FILE SEQUENCE NUMBER**.

Carton Number Lookups

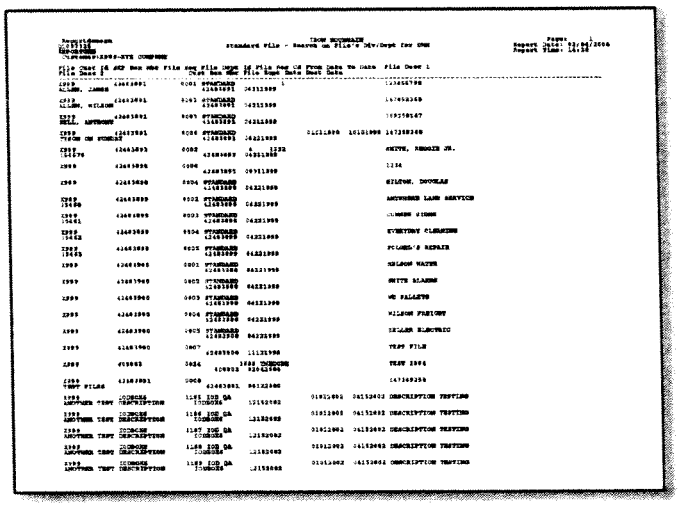
The ***Inventory Report*** and ***Supplemental Reports*** are used to research carton numbers for retrieval. The standard ***Inventory Report*** sorts left-to-right across the page by **DIVISION ID**, **DEPARTMENT ID**, **RECORD CODE**, **FROM** and **TO DATE RANGES**, **MAJOR DESCRIPTION**, **MINOR DESCRIPTION** and **CUSTOMER BOX NUMBER**.



Look up the **DIVISION ID**, **DEPARTMENT ID** and the **RECORD CODE** (if any) of the carton you are researching and use the rest of the inventory description to determine the carton number. At this point, you are ready to place retrieval orders through Iron Mountain Connect, etc. Both your **CUSTOMER BOX NUMBER** and the unique **SKP BARCODE NUMBER** are listed on the ***Report***, and either may be used for order entry purposes. If you know that your account has repeating **CUSTOMER BOX NUMBERS**, please use the ***Report*** to look up the unique **SKP BARCODE NUMBER** before placing your order.

Individual File Lookups

Use the ***File Inventory*** and ***Supplemental Reports*** to research your *individually listed* files in storage at Iron Mountain. The **FILE SEQUENCE NUMBER**, **FILE DESCRIPTION(S)**, **CUSTOMER BOX NUMBER**, and unique **SKP BARCODE NUMBER** for each individually listed file are displayed. To retrieve an individually listed file, provide all or part of the **FILE DESCRIPTION** during order entry. Or, to place your request in the most efficient way possible, use the combination of the **SKP BARCODE NUMBER** with the **FILE SEQUENCE NUMBER**.



For more information about locating your inventory, please contact your Iron Mountain Account Manager.

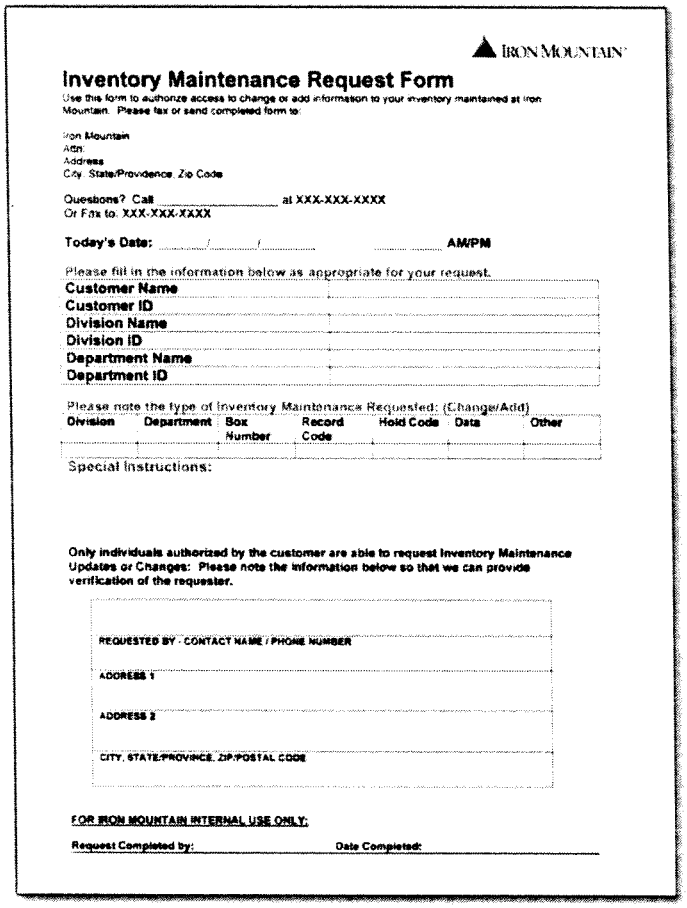
Inventory Maintenance Request Form

The Inventory Maintenance Request Form is used for changing information for inventory located in SafeKeeperPLUS system. "***Inventory Maintenance***" is also known as either box or file maintenance, and includes the changing of information in the field listed at the transmittal/box level such as: **Customer Box Number**, **Division/Department Code**, **Record Code, From/To Dates**, **Major/Minor Description**, **Hold Codes**, **Destruction Date/Indicator**, and others, ***except*** the **Reference 2** and **Receipt Date** fields.

Requests to have Inventory Maintenance updates, changes or transfers can only be made by individuals authorized by your organization.

When your organization transfers boxes from one **Account ID** to another, you may want to establish new **Department Codes** and **Record Codes**, or inactivate unused **Department Codes** and **Record Codes**. Please use the "***Special Instructions***" box to communicate this information to Iron Mountain.

Requests may be faxed or e-mailed to Iron Mountain.



IRON MOUNTAIN

Inventory Maintenance Request Form

Use this form to authorize access to change or add information to your inventory maintained at Iron Mountain. Please fax or send completed form to:

Iron Mountain
Attn:
Address
City, State/Providence, Zip Code

Questions? Call _____ at XXX-XXX-XXXX
Or Fax to: XXX-XXX-XXXX

Today's Date: ____/____/____ ____ **AM/PM**

Please fill in the information below as appropriate for your request.

Customer Name	
Customer ID	
Division Name	
Division ID	
Department Name	
Department ID	

Please note the type of Inventory Maintenance Requested: (Change/Add)

Division	Department	Box Number	Record Code	Hold Code	Date	Other

Special Instructions:

Only individuals authorized by the customer are able to request Inventory Maintenance Updates or Changes: Please note the information below so that we can provide verification of the requester.

REQUESTED BY - CONTACT NAME / PHONE NUMBER
ADDRESS 1
ADDRESS 2
CITY, STATE/PROVINCE, ZIP/POSTAL CODE

FOR IRON MOUNTAIN INTERNAL USE ONLY:

Request Completed by: **Date Completed:**

For more information about establishing Authorized Users, please contact your Iron Mountain Account Manager.

Order Placement Methods

Orders may be placed by using any one of four methods:

1. **Via the INTERNET** to access Iron Mountain Connect, Iron Mountain's online records management portal, at **www.imconnect.com**. Contact your Iron Mountain Account Manager for more information about this service.
2. **Via TELEPHONE** by simply calling Iron Mountain Customer Service. A fully trained representative will take your order and confirm all of the information about your request, immediately and courteously.
3. **Via FAX** by simply completing and transmitting the Iron Mountain ***Fax Order Form***.
4. **Via E-MAIL** for those Customers with e-mail access to the Internet, by completing and transmitting the Iron Mountain Fax/Email From to Iron Mountain's e-mail address, **order@imrm.com**. Be sure to include all of the pertinent inventory and transportation information as you would for an online, phone, or fax order.

Online Ordering: Using the Iron Mountain Connect Record Center

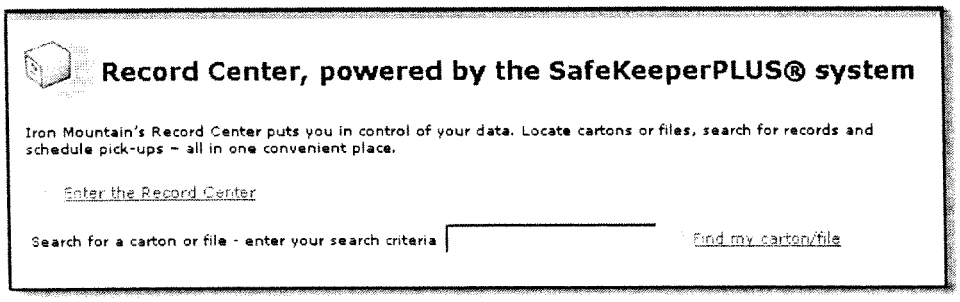
The Iron Mountain Connect is powered by the SafeKeeperPLUS system, provides you with a real-time, web-based means to access all of your records management information maintained at Iron Mountain. With its intuitive, user-friendly graphical user interface, you can perform many records management functions directly from your desktop. To request additional information, or to inquire about establishing access to Iron Mountain Connect, contact your Iron Mountain Account Manager.

Iron Mountain Connect Offers an Easy Way to:

- Manage your organization's records management policies, procedures, and retention schedule
- Conduct research on the current status and history of carton- or file-level inventory
- Place orders for pickups, retrievals, refiles, supplies, and permanent withdrawals
- Check on the status of previously placed orders
- Input information about new cartons and files to be transmitted to Iron Mountain
- Maintain and modify descriptive information on any inventory
- Initiate online invoice inquiries
- Request and receive online reports that help you monitor your records management program
- Receive valuable records management program information and resources

Getting Started

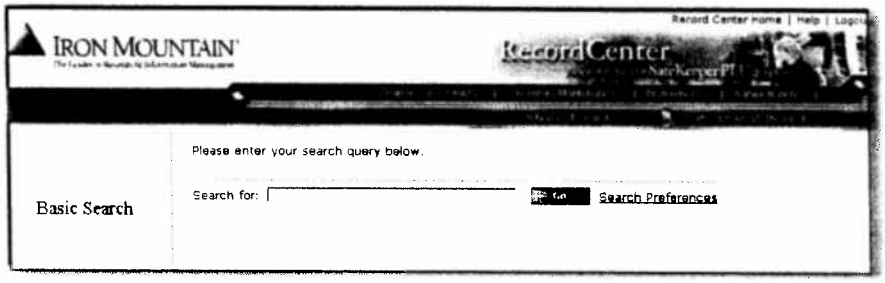
Log onto the Internet. Double-click your browser icon. Enter the URL: **www.imconnect.com**. The Iron Mountain Connect login screen appears. Enter your Username and Password. From the home page, in the module labeled



Your Iron Mountain Account Manager will help you to initially define Login IDs and appropriate security levels for your organization, as well as establish your confidential access to the Iron Mountain Connect records

The **Record Center SEARCH BAR** and **MAIN MENU** appear. From the **MAIN MENU**, some or all of these tasks may be displayed depending on your individual security level. Click on the desired option.

- Search
- Orders
- Inventory Maintenance
- Preferences
- Administration



Entering Orders via The Record Center

Select the type of order from the **Order** menu:

- **New Order** (for retrievals)
- **Pickup Order**
- **Supply Order**

The **ORDER TYPE** selected determines the information that the user is prompted for next.

Checking Out

From your **Cart** you can select the items you want to order from storage. You can also enter the delivery method and special instructions for each item.

On the **Checkout** page, do the following:

1. Make sure the delivery address is correct (if it is not, click **Change Address** and select an address from your Address Book)
2. In the Priority section, select a delivery date and time
3. Enter a carrier, instructions, confirmation e-mail address, and other order options
4. Enter the Division and Department to be billed (if necessary)
5. Enter the P.O. Number - up to 17 characters (if required)
6. Enter the Chargeback Code - up to 20 characters (if necessary)
7. From a dropdown list, select who the requested item is for, or enter the information manually

The **SERVICE LEVEL**, a required field, defaults to **NEXT DAY**, however, you can choose from **Next Day, Half Day, Rush**, or **Scheduled** (future date). The **CARRIER** defaults to Iron Mountain. Review the **SPECIAL INSTRUCTIONS** for this order (if any), and change if necessary. To place the order, click **Proceed to checkout** followed by **Submit Request**. A confirmation screen will appear, notifying the User that the order was placed. You can search for the Order Number by clicking **Order Inquiry** under the Orders Menu.

This is only a sample of what the Iron Mountain Connect Record Center can do for you. For more information, contact your Iron Mountain Account Manager.

Using the Iron Mountain Fax/Email Order Form - Records Management Orders

When you have multiple transactions such as retrieval, pickup and supply orders, the ***Fax/Email Order Form*** provides a convenient way for you to organize the information you need to efficiently place your order. Additionally, it acts as a hard copy backup for your records. If you request multiple transactions regularly, contact your Iron Mountain Account Manager for information about performing transactions through the Iron Mountain Connect records management portal.

A blank ***Fax/Email Order Form*** should be used as a **master** for making photocopies. Some helpful hints:

❶ Make photocopies of the blank form for each person in your organization who places orders.

❷ Have each User complete the standard information used for orders, such as his/her **NAME** and **PHONE NUMBER**, your **CUSTOMER ID** and **CUSTOMER NAME**, **DIVISION ID** and/or **DEPARTMENT ID**, and the **SHIPPING ADDRESS** (if the same address is always used).

❸ Photocopy the ***Form*** that contains all of the standard information. That way, each time you place an order you'll only need to fill in the variable information such as carton number to be retrieved, number of refiles to be picked up, or quantity of empty cartons needed.

IRON MOUNTAIN®

Fax/Email Order Form – Records Management Orders

Use this form to place orders via fax to: **USA: 1-800 934-5348, Canada: 1-800 387-0124, Maritimes: 1-800 316-2484, or via email at: order@ironmountain.com**
Questions? Call Customer Response at 1 800 FASTFILE

Today's Date: ____/____/____ ____:____ **AM PM**

Required Information: *(Order cannot be processed with out this information)*

Customer ID: _____ ***Service Level: Please Circle:*** Next Day Half Day Rush After-Hours Rush

If Applicable:

Division ID: _____ **Authorized User:** _____

Department ID: _____ **Password:** _____

Required: Delivery/Pick-Up Address: *(Order cannot be processed with out this information.)*

Company Name: _____

Attention: _____ **Phone:** ____/____-____

Address: _____ **Floor/Suite:** _____

City: _____ **ST/PROV:** _____ **Zip/Postal Code:** _____

E-Mail Address: _____@_____

Special Instructions: _____

ORDER TYPE: ☐ **RETRIEVAL** ☐ **FAX & REFILE** ☐ **INTERNAL PROJECT** ☐ **PERMANENT WITHDRAWAL**

CUSTOMER BOX NUMBER	SafeKeeperPLUS® (SKP) Box Number (Barcode Number)	FILE DESCRIPTION or FILE SEQUENCE # (4 DIGITS) (If Individual File Request)	Entire Box or Individual File	REQUESTED FOR (5 spaces)

ORDER TYPE: ☐ **PICKUP**

DESCRIPTION	QUANTITY	CARTON TYPE (Size)
New Cartons	_____	_____
Entire Carton Refiles	_____	_____
Individual File Refiles	_____	
Interfiles (New Files)	_____	

Common Carton Sizes:

Cubic Footage	Dimensions	Model #
1.2	15" x 12" x 10"	2000
2.4	24" x 12" x 10"	450
3.6	24" x 15" x 10"	550

ORDER TYPE: ☐ **SUPPLIES**

QUANTITY	ITEM
_____	#2000 Carton (10/pk), 1.2 cubic feet
_____	#_____, _____ cubic feet
_____	Transmittal Sheets (50/pad w/ 250 labels)
_____	Transmittal Forms (3 part, 25/pk)
_____	_____ Other Supply Item (specify)

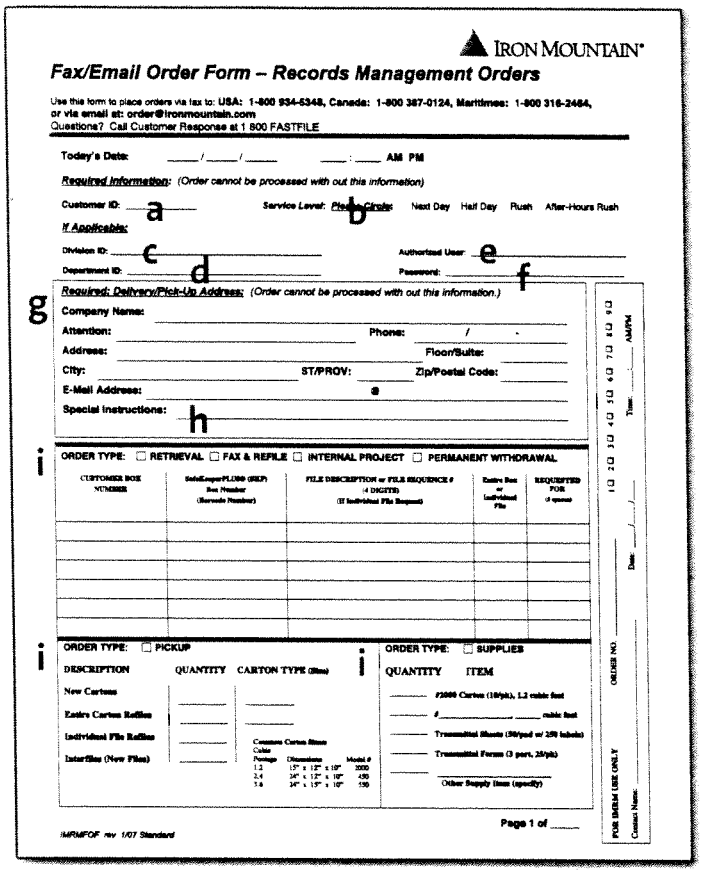
FOR IMRM USE ONLY
Contact Name: _____
ORDER NO. _____
Date: ____/____/____
Time: _____ AM/PM
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

Page 1 of ____

IMRMFOF rev 1/07 Standard

Completing the Iron Mountain Fax/Email Order Form

Complete the ***Fax/Email Order Form*** as shown below and fax it to Iron Mountain at the fax number listed at the top of the ***Form***. If you require more room for your order, a ***Fax/Email Order Form, 2nd Page*** ia also available.



IRON MOUNTAIN

Fax/Email Order Form – Records Management Orders

Use this form to place orders via fax to: USA: 1-800 934-5348, Canada: 1-800 387-0124, Maritimes: 1-800 316-2484, or via email at: order@ironmountain.com
Questions? Call Customer Response at 1 800 FASTFILE

Today's Date: ___/___/___ ___:___ AM PM

Required Information: (Order cannot be processed with out this information)

Customer ID: a Service Level: Please Circle: b Next Day Half Day Rush After-Hours Rush

If Applicable:

Division ID: c Authorized User: e

Department ID: d Password: f

g Required: Delivery/Pick-Up Address: (Order cannot be processed with out this information.)

Company Name:

Attention: Phone: / -

Address: Floor/Suite:

City: ST/PROV: Zip/Postal Code:

E-Mail Address: @

Special Instructions: h

i ORDER TYPE: ☐ RETRIEVAL ☐ FAX & REFILE ☐ INTERNAL PROJECT ☐ PERMANENT WITHDRAWAL

CUSTOMER BOX NUMBER	SafeKeeperPLUS (SKP) Box Number (Barcode Number)	FILE DESCRIPTION or FILE SEQUENCE # (4 DIGITS) (If Individual File Request)	Entire Box or Individual File	REQUESTED FOR (4 spaces)

i ORDER TYPE: ☐ PICKUP

DESCRIPTION	QUANTITY	CARTON TYPE (Size)
New Cartons		
Entire Carton Refiles		
Individual File Refiles		
Interfiles (New Files)		

Common Carton Sizes

Cubic Footage	Dimensions	Model #
1.2	15" x 12" x 10"	3000
2.4	24" x 12" x 10"	450
3.6	24" x 15" x 10"	530

i ORDER TYPE: ☐ SUPPLIES

QUANTITY	ITEM
___	#2000 Cartons (100/pk), 1.2 cubic feet
___	#___ ___ cubic feet
___	Transmittal Sheets (50/pad w/ 250 labels)
___	Transmittal Forms (3 part, 25/pk)
___	Other Supply Item (specify)

Page 1 of ___

IMRMFOF rev 1/07 Standard

FOR INTERNAL USE ONLY: Date: ___/___/___ Time: ___ AM/PM ORDER NO. ___ Contact Name: ___

a. Print your **CUSTOMER ID**.

b. Choose the appropriate **SERVICE LEVEL** to tell us how quickly you need to have your request performed:

For Retrievals and Supplies:

- ***Next Day*** - Next business day.
- ***Half Day*** - Twice daily (AM/PM).
- ***Rush*** - Expedited on a *priority* basis ***during*** business hours.
- ***After-Hours Rush*** - Expedited on a *priority* basis ***after*** regular business hours.

For Pickups:

- ***Normal*** - Within *two* business days.
- ***Rush*** - Expedited on a *priority* basis ***during*** business hours.

c. Print the **DIVISION ID** (the name or number of your organizational business unit associated with this order for billing purposes), if applicable.

d. Print the **DEPARTMENT ID** (the name or number of the department or cost center associated with this order for billing purposes), if applicable.

e. Print the name of an **AUTHORIZED USER** from your organization (an established representative who is permitted to place orders on your behalf), if applicable.

f. Print the Authorized User's **PASSWORD** (a customer-created code established on a per Authorized User basis), if applicable.

g. Print the delivery/pickup address information, or provide your **ADDRESS CODE**, if known. Be sure to include the e-mail address of the recipient.

h. Include **SPECIAL INSTRUCTIONS** if there is anything unique about this particular order.

i. Choose an **ORDER TYPE**:

Retrieval*, Internal Project, or Permanent Withdrawal - Access to cartons or files already in storage at Iron Mountain.

Fax & Refile* - Access to cartons or files already in storage at Iron Mountain that will be faxed to the Recipient's attention and then refiled.

Pickup - Pickup of new or previously retrieved cartons or files. Indicate the number of cartons scheduled for pickup under the ***"Quantity Heading"*** and the carton size, under the ***"Carton Heading".***

Supplies - Delivery of additional forms or empty cartons. ***Please be sure this section is completed when requesting supplies.***

*For ***Retrievals:***

- Check the type: **Retrieval**, **Fax & Refile**, **Internal Project**, or **Permanent Withdrawal**.
- Print the **CUSTOMER BOX NUMBER** or **SafeKeeperPLUS (SKP) BARCODE NUMBER** of the carton to be retrieved, which can be found on your ***Inventory*** or ***Supplemental Reports***.
  - For ***individual files***, name or describe the file in **FILE DESCRIPTION**, and print *'IF'* in the **ENTIRE BOX or INDIVIDUAL FILE** field.
  - For ***entire cartons***, print *'EB'* in the **ENTIRE BOX or INDIVIDUAL FILE** field.
- Print the *End User's* name or initials in the **REQUESTED FOR** field for each line item to help you efficiently distribute the materials internally.

Using the Iron Mountain Fax/Email Order Form - Shredding Orders

When you have multiple transactions such as retrieval, pickup and supply orders, the ***Shredding Fax/Email Order Form*** provides a convenient way for you to organize the information you need to efficiently place your order. Additionally, it acts as a hard copy backup for your records. If you request multiple transactions regularly, contact your Iron Mountain Account Manager for information about performing transactions through the Iron Mountain Connect records management portal.

A blank ***Shredding Fax/Email Order Form*** should be used as a **master** for making photocopies. Some helpful hints:

❶ Make photocopies of the blank form for each person in your organization who places orders.

❷ Have each User complete the standard information used for orders, such as his/her **NAME** and **PHONE NUMBER**, your **CUSTOMER ID** and **CUSTOMER NAME**, **DIVISION ID** and/or **DEPARTMENT ID**, and the **SHIPPING ADDRESS** (if the same address is always used).

❸ Photocopy the ***Form*** that contains all of the standard information. That way, each time you place an order you'll only need to fill in the variable information such as carton number to be retrieved, number of refiles to be picked up, or quantity of empty cartons needed.

IRON MOUNTAIN®

Fax/Email Order Form - Shredding Orders

Use this form to place orders via fax to: **USA: 1-800 934-5348, Canada: 1-800 387-0124, Maritimes: 1-800 316-2464, or via email at: order@ironmountain.com**
Questions? Call Customer Response at 1 800 FASTFILE

This form shall be used for requests to Iron Mountain for the following Shredding services only:
1) Empty Container/Console - bins are full and require additional service before the scheduled service date.
2) Requirement of an additional container/console
3) Removal of Container/Console – consoles/containers are not being used.
Please note: this form is not for Scheduled Services

Today's Date: _____/_____/_____ **(You will be notified of your service date)**

Required Information: *(Order cannot be processed with out this information)*

Customer ID: _____

Requestors Name: _____ **Phone:** _____/_____-_____

If Applicable:

Division ID: _____ **Authorized User:** _____

Department ID: _____ **Password:** _____

Required: Service Location Address: *(Order cannot be processed with out this information.)*

Company Name: _____

Contact Name: _____ **Phone:** _____/_____-_____

Address: _____ **Floor/Suite:** _____

City: _____ **ST/Prov.:** _____ **Zip/Postal Code:** _____

E-Mail Address: _____@_____

Special Instructions:

ORDER TYPE:

☐ **On-Site Shredding** **(Shredding will take place at your location with a Mobile Shred Truck)**

☐ **Off-Site Shredding** **(Materials to be shredded are removed from the customer location & shredded at IM)**

___Empty containers	Total number of containers	____ Container/65 gal	_____ Console
___Add containers	Total of additional containers needed	____ Container/65 gal	_____ Console
___Remove containers	Total number of containers to be removed	____ Container/65 gal	_____ Console
___Non-Archival Boxes	Total number of boxes _____ (Note: this order would be Off Site Shredding)		

All other service requirements (shred other items, change service frequency, closing location, etc.): Please contact Customer Response for assistance: 1-800-FASTFILE

Completing the Iron Mountain Shredding Fax/Email Order Form

Complete the ***Shredding Fax/Email Order Form*** as shown below and fax it to Iron Mountain at the fax number listed at the top of the ***Form***. It's that simple!

IRON MOUNTAIN

Fax/Email Order Form - Shredding Orders

Use this form to place orders via fax to: USA: 1-800 934-5348, Canada: 1-800 387-0124, Maritimes: 1-800 316-2464, or via email at: order@ironmountain.com
Questions? Call Customer Response at 1 800 FASTFILE

This form shall be used for requests to Iron Mountain for the following Shredding services only:
1) Empty Container/Console - bins are full and require additional service before the scheduled service date.
2) Requirement of an additional container/console
3) Removal of Container/Console – consoles/containers are not being used.
Please note: this form is not for Scheduled Services

Today's Date: ____/ a /____ (You will be notified of your service date)

Required Information: *(Order cannot be processed with out this information)*

Customer ID: b

Requestors Name: c Phone: ____/ d -

If Applicable:

Division ID: e Authorized User: g

Department ID: f Password: h

i *Required: Service Location Address:* *(Order cannot be processed with out this information.)*

Company Name:

Contact Name: Phone: / -

Address: Floor/Suite:

City: ST/Prov.: Zip/Postal Code:

E-Mail Address:

Special Instructions:

J ORDER TYPE:

☐ On-Site Shredding (Shredding will take place at your location with a Mobile Shred Truck)

☐ Off-Site Shredding (Materials to be shredded are removed from the customer location & shredded at IM)

___Empty containers	Total number of containers	____ Container/65 gal	____ Console
___Add containers	Total of additional containers needed	____ Container/65 gal	____ Console
___Remove containers	Total number of containers to be removed	____ Container/65 gal	____ Console
___Non-Archival Boxes	Total number of boxes ____ (Note: this order would be Off Site Shredding)		

All other service requirements (shred other items, change service frequency, closing location, etc.): Please contact Customer Response for assistance: 1-800-FASTFILE

a. Print **"TODAY'S DATE"**. You will be notified of your service date.

b. Print your **CUSTOMER ID**.

c. **REQUESTOR'S NAME**: The person within your company making the request.

d. **PHONE:** Requestor's phone number.

e. Print your **DIVISION ID** (if used by your company) to specify ownership of individual records

F. If used by your company, the **DEPARTMENT ID**, that is, the name or number of the department or cost center associated with this order for billing purposes

G. If you have requested that only certain people have access to place orders for your company, enter the **AUTHORIZED USER**

H. If you have requested that the user on the account be **PASSWORD** protected, enter the user's password

I. Print the **SERVICE LOCATION** for pickup/delivery.

J. Choose an **ORDER TYPE**

When Placing Your Order

Regardless of the type of order you're placing, or the method you're using to place your order, you'll be asked to verify and/or provide some basic information along with the specifics related to your order.

❶ Your four- or five-digit **CUSTOMER ID**.

❷ Your **CUSTOMER NAME**.

❸ The **DIVISION ID**, if applicable. Must be established prior to use. Contact your Iron Mountain Account Manager for more information.

❹ The **DEPARTMENT ID** if departmentalized billing for services performed is used. If one department is placing the request but another department is being billed, you may note *both* departments on the order.

❺ The **AUTHORIZED USER**, a representative from your organization who is permitted to access your account, and his/her **PASSWORD**, if applicable.

❻ Your **PURCHASE ORDER NUMBER**, if applicable.

❼ The desired **ORDER TYPE**: Retrieval, Fax and Refile, Internal Project, Permanent Withdrawal, Pickup, or Supplies.

❽ The **LOCATION**, including **ADDRESS**, **FLOOR**, **NAME**, **PHONE NUMBER**, **EXTENSION**, and **E-MAIL ADDRESS** of the person who will be receiving the delivery, or is responsible for the pickup.

❾ To ***RETRIEVE*** cartons or files from storage, you'll need:

- The **CUSTOMER BOX NUMBER** or **SafeKeeperPLUS (SKP) BARCODE NUMBER** (the **SKP BARCODE NUMBER** is especially important if your **CUSTOMER BOX NUMBERS** repeat).
- For *individual files*, describe, specifically, the record needed. Include the **CUSTOMER BOX NUMBER** or **SKP BARCODE NUMBER**. If your files are *individually listed*, you may use either the **FILE DESCRIPTION** or the **FILE SEQUENCE NUMBER** from your most recent ***File Inventory*** or ***File Supplemental Reports***.
- Any **SPECIAL INSTRUCTIONS** or restrictions regarding the delivery.

To request a ***PICKUP***, you'll also need to provide:

- The **type** of records to be picked up: ***New Cartons***, ***Entire Carton Refiles***, ***Individual File Refiles***, ***Interfiles***, or ***Tapes/Vital Records***.
- The exact **QUANTITY** and **SIZE** of the cartons and/or number of files so that an appropriately sized vehicle can be dispatched.
- Any **SPECIAL INSTRUCTIONS** or restrictions regarding the pickup.

To order ***SUPPLIES***, you'll also need to provide:

- The **CARTON TYPE**, **DESCRIPTION**, or **DIMENSIONS** of the carton; or, the **TITLE** or **FORM NUMBER** of the form you need.
- The exact **QUANTITY** desired (typically packaged in incremental quantities).
- Any **SPECIAL INSTRUCTIONS** or restrictions regarding the delivery.

❿ The desired **SERVICE LEVEL**, which is based on your contract, the **ORDER TYPE** selected, and the time your order was placed. Options include: Next Day, Half Day, Rush, After-Hours Rush.

An Acknowledgement of Your Transaction

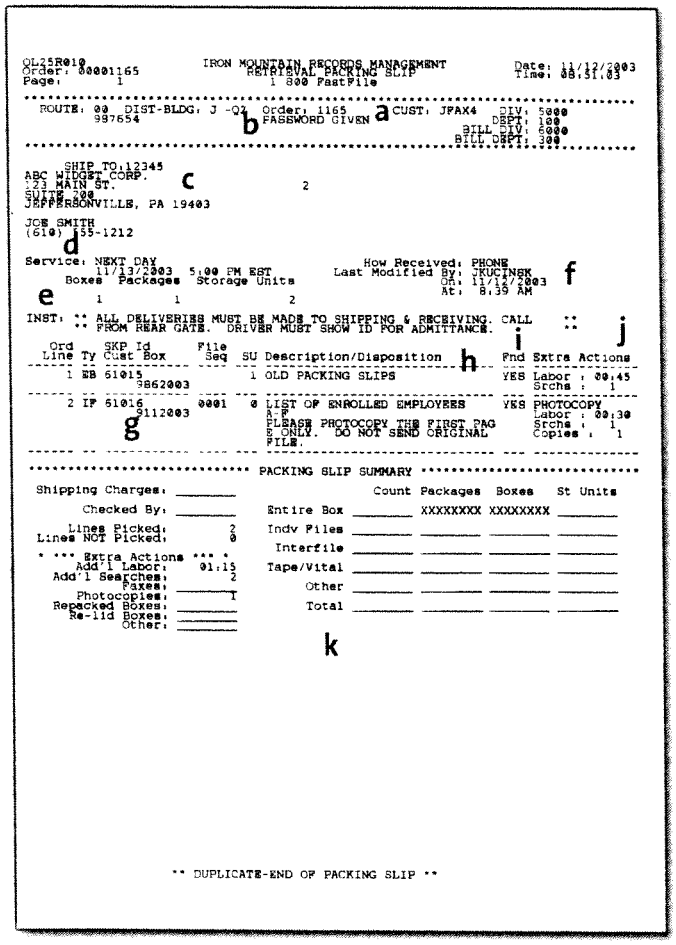
Your Iron Mountain Order Number

When you place your order via Iron Mountain Connect or by telephone, Iron Mountain will provide you with an **ORDER NUMBER** which confirms that the order was accepted. Please make a note of it because it will appear on all documentation generated as a result of this transaction.

When you use any other order placement method, and you require an **ORDER NUMBER**, please clearly state that on your request. An Iron Mountain Representative will be happy to call, fax, or e-mail the order number to you.

Reviewing Your Packing Slip

The ***Packing Slip*** is a comprehensive acknowledgement of your order. It ensures accurate communication between Iron Mountain and you and is designed to provide pertinent, order-specific information. The Iron Mountain driver will give you a copy of the ***Packing Slip***. Save this copy for your records. ***Packing Slips*** may include multiple pages and will vary depending on the type of order being fulfilled, but certain features appear on all:



a. The **ORDER NUMBER**, as well as your **CUST**[OMER] **ID**, **DIVISION ID**, and/or **DEPARTMENT ID**. If the order was charged to a Division/Department other than the *ordering* Division/Department, that information will display next to **BILL DIV** and **BILL DEPT**.

b. Provided that you use passwords, **PASSWORD GIVEN** indicates that the proper security measures were followed by the Authorized User, as well as the Iron Mountain Representative.

c. **ATTENTION (CONTACT) NAME** and **SHIP TO ADDRESS** with **PHONE NUMBER**.

d. **DATE** and **SERVICE LEVEL** of the order.

e. **ORDER-LEVEL SPECIAL INSTRUCTIONS (INST)** regarding this order enable prompt and accurate pickups and deliveries.

f. The **DATE** and **TIME** you placed the order, as well as how the order was received by Iron Mountain.

g. The **SKP ID** (SafeKeeperPLUS BARCODE NUMBER) and **CUSTOMER BOX NUMBER**. EB (*Entire Carton*) or IF (*Individual File*) describes the type (**TY**) of item requested.

h. Details and descriptions about each service transaction at the carton or file level. **SPECIAL INSTRUCTIONS**, which pertain to *this order line only*, appear here. **DESCRIPTION/DISPOSITION** relays pertinent information regarding the item.

i. The **FND** column indicates whether the item requested was *Found* or *Not Found* (YES or NO).

j. An **EXTRA ACTIONS** field displays the type of extra action(s) taken for that particular item, if any, as well as the quantity of actions performed.

k. A ***Packing Slip Summary*** displays the total number of *Found* items (**Lines Picked**), *Not Found* items (**Lines NOT Picked**), **Extra Actions** taken, if any, and, the total number of **Boxes**, **Packages**, and **Storage Units**.

Customer and driver signatures appear on Iron Mountain ***Daily Vehicle Logs*** and validate services performed.

Reviewing Your Outcard/Outcard Label

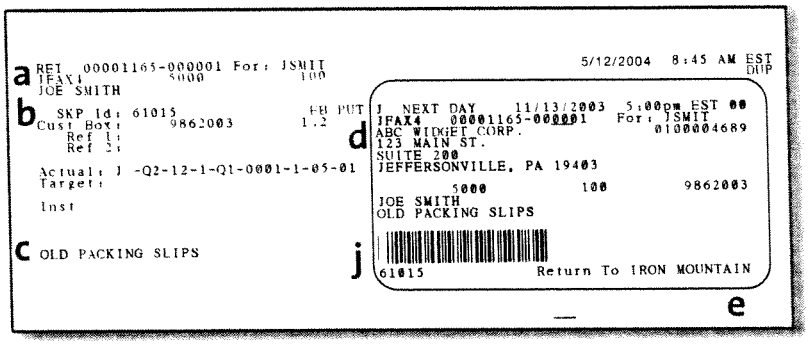
The Iron Mountain ***Outcard*** assists in the maintenance of inventory history. It is used to locate needed inventory when you request it, and acts as a place marker for an individual file that is pulled from its carton or open file shelf location during a retrieval. The barcoded, self-adhesive label contains an abbreviated version of the ***Packing Slip*** information and is placed on the outside of the carton or file that has been retrieved, thereby facilitating delivery within your organization as well as proper refiling at Iron Mountain.

Outcards vary depending on the type of order being fulfilled. For example, the ***Open Shelf*** label is smaller than a hardcopy label, therefore, only the critical fields needed to retrieve and deliver the correct file are displayed. Standard features of the hardcopy ***Outcard/Outcard Label*** include:

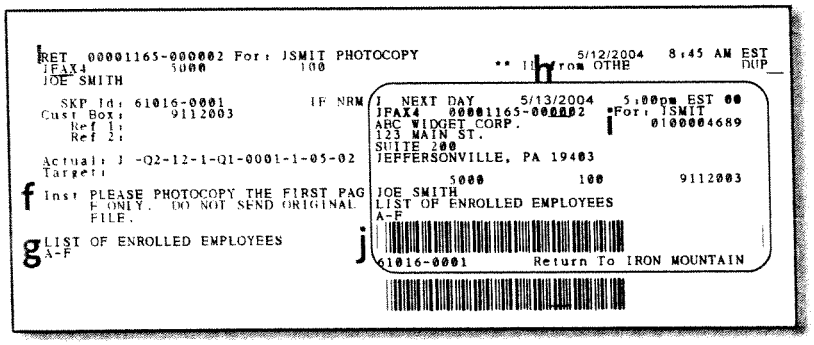
a. The **ORDER TYPE**, **ORDER NUMBER** and **LINE**, **CUSTOMER ID** and **DEPARTMENT ID**.

b. The **SKP ID** (SafeKeeperPLUS BARCODE NUMBER) and **CUSTOMER BOX NUMBER**, if any.

c. Previous **HISTORY** (if any) relays pertinent information regarding the item. For example, if the item was previously outcarded, the Requester and date requested are displayed.



Outcard for a Retrieved Carton



Outcard for a Retrieved File from a Carton

Outcard for a Retrieved File from an Open Shelf Location

d. **ATTENTION (CONTACT) NAME** and **SHIP TO ADDRESS**.

e. The record center clerk's initials appear in this corner to validate the retrieval of the item.

f. **LINE-LEVEL SPECIAL INSTRUCTIONS** refer only to that particular item, providing information helpful in retrieving and/or refiling the item.

g. The description of the file as it was entered during order entry.

h. **SERVICE LEVEL**, **TRANSPORTATION DATE**, and **TIME**.

i. The **FOR** (Requested For) identifies the End User who is actually receiving the item.

j. Barcode technology ensures that inventory and related paperwork are processed quickly and accurately.

For more information about how to read your Packing Slip and/or Outcard, please contact your Iron Mountain Account Manager.

Permanent Withdrawal and Destruction

In a properly maintained records management program, inventory is monitored to ensure the timely removal, when appropriate, of records from storage. Descriptive information and retrieval activity patterns for these records should be reviewed prior to making any removal decisions.

At Iron Mountain, there are two types of removal: Permanent Withdrawal and Destruction.

- ***Permanent Withdrawal** is the Customer-initiated process of removing a carton or file from inventory with **no intention of sending it back to storage**. Once permanently withdrawn, the record is assigned a WTH (withdrawn) status and the Customer is no longer charged for storage on that record.*
- ***Destruction** is the process by which Customer-authorized records are **permanently disposed of** by Iron Mountain by one of two methods: **recycling** or **secure shredding**. Once destroyed, the record is assigned a DST (destroyed) status and the Customer is no longer charged for storage on that record.*

Permanent Withdrawal

A **Permanent Withdrawal** is a special type of retrieval order. By following the established authorization procedures for your organization, you can permanently withdraw records the same way you would request a typical retrieval: online through the Iron Mountain Connect records management portal, phone, fax, or e-mail. If ordering online, simply select the 'Permanent Withdrawal' order type. If ordering by fax, check the 'Permanent Withdrawal' order type box; if ordering by e-mail, indicate that, "the following items are for permanent withdrawal." And, if ordering by phone, instruct the Iron Mountain Representative *at the beginning of your order* that you "would like to permanently withdraw the following items". Doing so ensures that your permanent withdrawal request will be processed accurately and in the most efficient way possible.

NOTE: If you make frequent withdrawal orders, or would like to permanently withdraw a large percentage of your inventory, please contact your Iron Mountain Account Manager.

Once permanently withdrawn, each record's inventory history is updated to a WTH (withdrawn) status. Beginning with your next regular billing cycle, you will no longer pay for storage on that record. Upon delivery of your permanently withdrawn items, you will receive a ***Packing Slip*** which details each withdrawn item and its current disposition.

If you have previously retrieved records from storage but did not indicate at that time that they should have been permanently withdrawn, please provide Iron Mountain with written authorization (by an Authorized User from your organization) to have them permanently withdrawn from your inventory. Upon receipt of the authorization, Iron Mountain will create a permanent withdrawal order for the records, which discontinues further storage charges and updates each record's disposition to 'WTH'.

Destruction

Selecting the appropriate destruction method for your organization based on the types of records you store and their retention schedule requirements is an important decision to make in the records management life cycle. Iron Mountain offers two types of destruction options:

- ***Recycling**: Under this method, a recycler destroys the customer's records. Iron Mountain is not responsible for the security of records once the recycler has taken possession of the materials. For more information, please see page 9.*
- ***Secure Shredding**: Under this method, Iron Mountain destroys records by shredding; rendering those materials beyond reconstruction by reasonable procedures. At all times prior to physical destruction, records are in the secured custody of Iron Mountain. Upon completion, a certificate of final disposition is provided, indicating that the material was destroyed by shredding.*

Upon written authorization from an **Destruction Authorized User** in your organization, Iron Mountain will initiate the destruction process based on the method(s) you choose.

Identifying Records for Destruction

There are two ways for a ***Destruction Authorized User*** to advise Iron Mountain about the records that have met their retention period and should be destroyed: by highlighting a ***Destruction Eligibility Report*** or ***Inventory Report***, and/or by using ***Specific Criteria***.

Requesting Destruction Using the Destruction Eligibility Report and/or Inventory Report. Iron Mountain provides comprehensive ***Inventory Reports*** of the cartons and individually listed files that you have in storage. From these ***Reports***, the **DESTROY DATES** of your inventory can be reviewed and identified for destruction.

1. Photocopy the ***Destruction Eligibility Report*** or ***Inventory Report*** and highlight the **CUSTOMER BOX NUMBER** and/or the **SafeKeeperPLUS (SKP) BARCODE NUMBER** of the record(s) to be destroyed.
2. Indicate the destruction method for each record on the ***Report***: *recycling* or *secure shredding*.
3. Attach a letter, signed by a ***Destruction Authorized User*** from your organization, to the ***Destruction Eligibility Report*** or ***Inventory Report***, which clearly states that the highlighted records are authorized for destruction by Iron Mountain.
4. Address this letter and the highlighted ***Report(s)*** to the Iron Mountain Data Entry department at your local Iron Mountain District. If you don't know that address, contact your Iron Mountain Account Manager.

Requesting Destruction Based on Specific Criteria. You may wish to create a destruction order with Iron Mountain based on a specific set of criteria; for example, all cartons that have passed a particular **DESTROY DATE**.

The criteria from which you can select are: **DESTROY DATE**, **RECEIPT DATE**, **FROM DATE**, **TO DATE**, **CUSTOMER BOX NUMBER**, **DIVISION ID**, **DEPARTMENT ID**, **RECORD CODE**, **DEPARTMENT ID/RECORD CODE** combination.

The **DIVISION ID**, **DEPARTMENT ID**, and/or **RECORD CODE** can also be used in conjunction with other criteria to limit the destruction order to records that meet the criteria and are inventoried to that **DIVISION ID**, **DEPARTMENT ID**, and/or **RECORD CODE**.

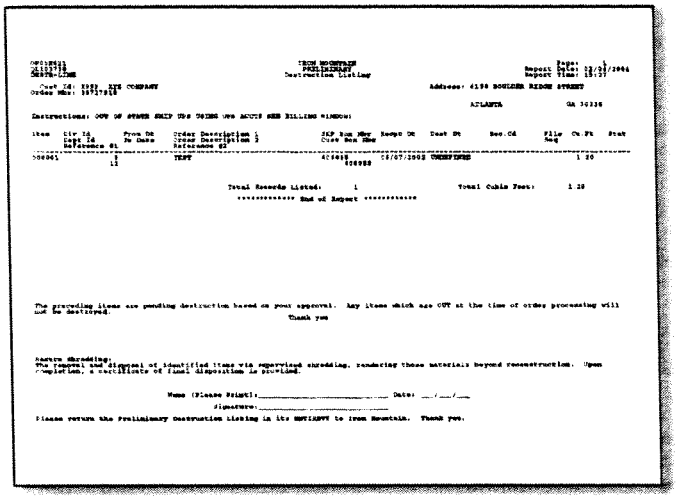
To create a destruction order using criteria, send a letter, signed by a ***Destruction Authorized User*** from your organization, to your local Iron Mountain District. If you don't know that address, contact your Iron Mountain Account Manager. Be sure to note the criteria and ranges to be used to create the destruction order.

Verification of Records for Destruction

Verification of the records you have selected for destruction is a two-step process.

The Preliminary Destruction Listing

Upon receipt of your destruction request(s), Iron Mountain creates a destruction order for each destruction method selected — *recycling* or *secure shredding* — from which a ***Preliminary Destruction Listing*** is generated and automatically sent to you along with an instructions letter. After carefully reviewing each ***Listing***, sign in the designated areas on both the ***Preliminary Destruction Listing(s)*** and the instructions letter and return them to Iron Mountain Data Entry at the Iron Mountain address clearly shown on the instructions letter so that the destruction order(s) may be processed.



If the ***Preliminary Destruction Listing(s)*** needs to be **changed**, proceed as follows:

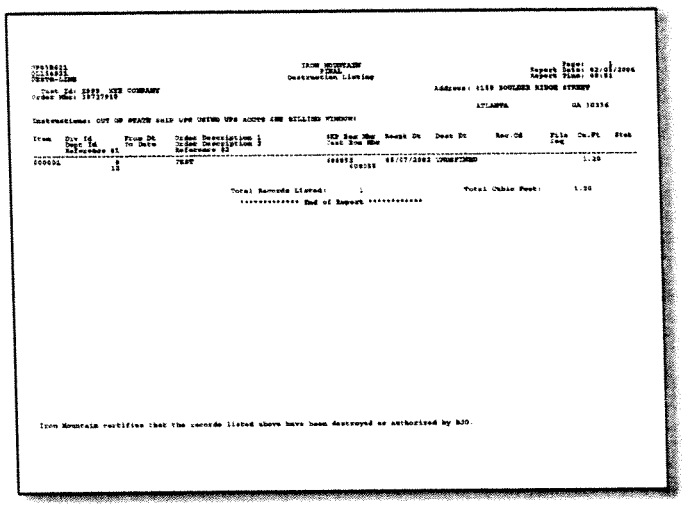
- **For each item that should *NOT* be destroyed:**
  1. With a single pen line, cross out the particular item and write 'DND' [do not destroy].
  2. Highlight the entire line, as well.
  3. Note any applicable updates about the item such as a new **DESTRUCTION REVIEW DATE** or **HOLD CODE**.
  4. Sign both the ***Preliminary Destruction Listing(s)*** and the instructions letter and return them to Iron Mountain Data Entry at the Iron Mountain address clearly shown on the instructions letter.

- **For each item that should be *ADDED* to the list for destruction:**
  1. Write the **CUSTOMER BOX NUMBER** and the **SKP BARCODE NUMBER** on the **last** page of the ***Listing***.
  2. Highlight these newly-listed items.
  3. Indicate the destruction method for each additional item — *recycling* or *secure shredding*.
  4. Sign both the ***Preliminary Destruction Listing(s)*** and the instructions letter and return them to Iron Mountain Data Entry at the Iron Mountain address clearly shown on the instructions letter.

NOTE: Iron Mountain will not destroy your inventory without the signed *Preliminary Destruction Listing(s)* and instructions letter from a ***Destruction Authorized User*** in your organization. If no selection is made, and the report is signed and returned by an authorized user, Iron Mountain will shred the identified material on the *Preliminary Destruction Listing(s).*

The Final Destruction Listing

After Iron Mountain receives your signed ***Preliminary Destruction Listing(s)*** and instructions letter, and the destruction order has been processed, a ***Final Destruction Listing*** is automatically generated and sent to you to confirm that the destruction of your records, as you specified, has been completed. If no selection was made, then Iron Mountain chose to maintain the security of your records by shredding the identified materials as previously indicated.



As a part of the destruction process, Iron Mountain maintains a record of the carton, changes the **STATUS** of the item to 'DST' [Destroyed by Iron Mountain], and creates a history record for the item which captures the **DATE OF DESTRUCTION**, the **ORDER NUMBER**, **DIVISION ID**, and **DEPARTMENT ID** of the division/department who requested the destruction (if applicable), as well as the **CONTACT** person for the destruction order.

Any item requested to be destroyed but that was previously Outcarded [OUT], Permanently Withdrawn [WTH], Destroyed by Iron Mountain [DST], or Destroyed by Your Organization [DSO] would be **excluded** from your destruction order request and, instead, be detailed on an accompanying ***Destruction Exception Report***. Outcarded records will continue to incur storage charges. If a record will **not** be returning to storage at Iron Mountain, **or**, if you have destroyed records at your own facility, please provide Iron Mountain with written authorization (from an Authorized User in your organization) to have them permanently withdrawn from your inventory. Upon receipt of the authorization, Iron Mountain will create a permanent withdrawal order for the records, which discontinues further storage charges and updates each record's disposition to 'WTH'.

If the status of an inventory item has ***changed*** between the time you originally requested that the item be destroyed and the time the destruction order was processed (after signing the ***Preliminary Destruction Listing*** and instructions letter), then a ***Status Change To Records On The Destruction Order Report*** is also included. This may occur if a record listed on the ***Preliminary Destruction Listing*** was subsequently retrieved from storage and delivered to you.

Certificate of Destruction

For those items where you requested *secure shredding* as the destruction method, a **Certificate of Destruction** statement will appear on your next Iron Mountain Invoice.

If you selected *recycling* as the destruction method, a **Certificate of Destruction** statement is not provided because, once out of its possession, Iron Mountain does not accept responsibility for records destroyed by this method.

For more information about removing records from storage, or selecting the appropriate destruction method for your organization, please contact your Iron Mountain Account Manager.

Understanding Your Invoice and Invoice Reports

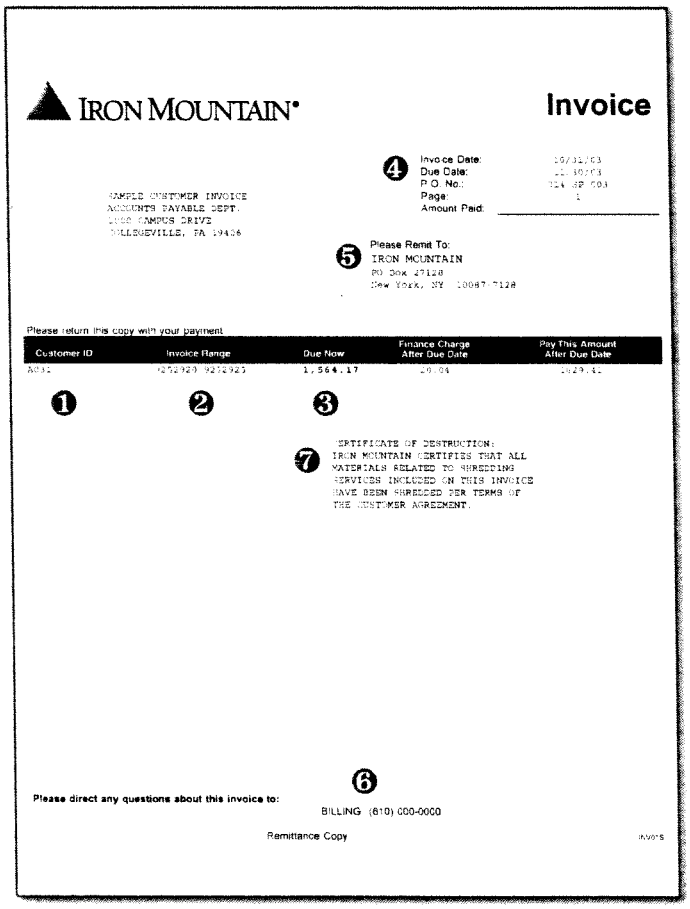
The Iron Mountain Invoice is concise and easy to read. And, the accompanying invoice reports are designed to provide you with a variety of options for summary- and detail-level reporting. Iron Mountain offers alternate invoice report delivery methods including the Iron Mountain Connect records management portal and electronic download download via e-mail.

The first page of your Invoice is the *Remittance Copy*, which clearly indicates the **CUSTOMER ID**, **INVOICE RANGE**, **DUE NOW**, **DUE DATE**, **REMITTANCE ADDRESS**, and **IRON MOUNTAIN CONTACT INFORMATION**. When paying your Iron Mountain Invoice, the *Remittance Copy* should be included with your payment. If you do not include the *Remittance Copy* with your payment, it is important that you include at least one invoice number on your check. The second page is the *Customer Copy*, an exact replica of the first page, which you should retain for your records.

❶ **CUSTOMER ID**
Unique identification assigned to your account. You should indicate your **CUSTOMER ID** on all correspondence and inquiries you make to Iron Mountain, including payments.

❷ **INVOICE RANGE**
Corresponds to each Invoice on the Billing/Activity Report. Please include this information on your payment.

❸ **DUE NOW**
The amount due for *this* Invoice. This amount does **not** include any Past Due charges.


IRON MOUNTAIN®

Invoice

❹ Invoice Date:
Due Date:
P.O. No.:
Page:
Amount Paid:

SAMPLE CUSTOMER INVOICE
ACCOUNTS PAYABLE DEPT.
2000 CAMPUS DRIVE
COLLEGEVILLE, PA 19426

❺ Please Remit To:
IRON MOUNTAIN
PO Box 27128
New York, NY 10087-7128

Please return this copy with your payment

Customer ID	Invoice Range	Due Now	Finance Charge After Due Date	Pay This Amount After Due Date
A031	9272923-9272923	1,564.17	20.04	1029.41
❶	❷	❸		

❼ CERTIFICATE OF DESTRUCTION:
IRON MOUNTAIN CERTIFIES THAT ALL MATERIALS RELATED TO SHREDDING SERVICES INCLUDED ON THIS INVOICE HAVE BEEN SHREDDED PER TERMS OF THE CUSTOMER AGREEMENT.

Please direct any questions about this invoice to:
❻ BILLING (610) 000-0000

Remittance Copy

INV01S

❹ **DUE DATE**
The date your payment is due to Iron Mountain.

❺ **REMITTANCE ADDRESS**
Address where all payments must be sent to ensure prompt application to your account.

❻ **IRON MOUNTAIN CONTACT INFORMATION**
The name and phone number of an Iron Mountain Billing Representative who can answer your questions, quickly and accurately.

❼ **CERTIFICATE OF DESTRUCTION**
Certification language displays on the Invoice *Remittance* and *Customer Copy* pages for those customers that have shredding-specific orders included on the Invoice.

Reading Your Billing/Activity Reports

The following is a list of the **most common transactions** with a brief description for each:

Destruction [Recycling] – The removal and disposal of identified items from storage via Iron Mountain or a third party to an Iron Mountain-certified recycling partner. Items awaiting destruction are secured while in Iron Mountain's possession; however the method of final disposal, timing, and disposition of content vary by location. Iron Mountain does not accept responsibility for such material once the recycler has taken possession of the materials.

Destruction Shred – The removal and disposal of identified items from storage via supervised shredding, rendering those materials beyond reconstruction. Upon completion, a Certificate of Destruction statement will appear on your Invoice.

Individual Listing – The per file charge for data entry of file descriptions into the SafeKeeperPLUS system.

Minimum Service Charge per Order – A minimum order charge applied to a Customer's account when the service order, excluding transportation-related charges, does not meet the Customer's contractual service order minimum.

Mnthly Min Strg Chrg – A minimum monthly storage charge that is applied to a Customer's account when the storage does not meet the Customer's contractual minimum storage requirement.

Off-site Shred – The charge for providing secure shredding services of non-archival documents at a secure shredding plant.

On-call Shred, Trip – The service of going to a Customer's location outside of the normal schedule for the purpose of picking up non-archival documents for secure shredding.

On-site Shred – The charge for providing secure shredding services of non-archival documents at the Customer's location via a Mobile Shredding Unit.

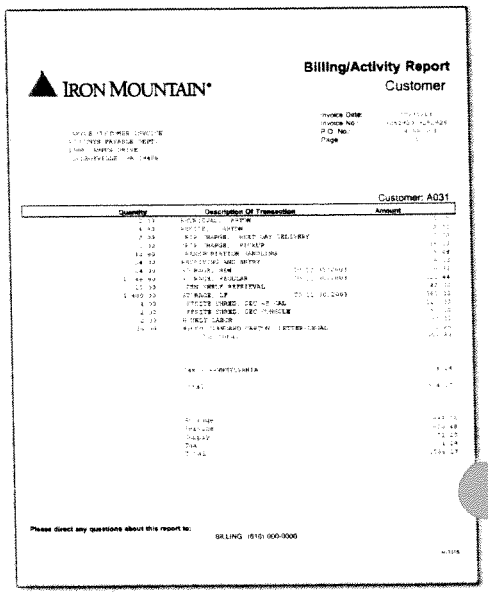
Open Shelf Retrieval – The act of physically locating and pulling a file from an open shelf storage location in an Iron Mountain facility based on criteria provided by the Customer.

Permanent Withdrawal – The removal of a carton or file from storage that will not be returning to storage.

Receiving and Entry – The charge applied when a new carton is sent to storage for the first time. The service includes scanning the new carton into an Iron Mountain facility, assigning it a location, and capturing the descriptive information from the Transmittal.

Refile – A carton or file, previously retrieved by the Customer (i.e., outcarded), which is returned to storage.

Retrieval – The act of physically locating and pulling a carton or file from an Iron Mountain facility based on criteria provided by the Customer. Any service performed in addition to the retrieval will be billed as a separate line item on the Invoice (e.g., permanent withdrawal, destruction, imaging, faxing, shredding).


IRON MOUNTAIN

Billing/Activity Report
Customer

Customer: A031

Quantity	Description Of Transaction	Amount

Please direct any questions about this report to:

Shred, Trip Scheduled – The service of going to a Customer's location on a predetermined schedule for the purpose of picking up non-archival documents for secure shredding.

Storage, LF – The linear foot (LF) charge for retention of files in an open shelf location at an Iron Mountain facility.

Storage, New – The cubic footage charge for retention of new cartons at an Iron Mountain facility for the month in which they are received, through the next regular billing cycle.

Storage, Regular – The cubic footage charge for retention of cartons at an Iron Mountain facility.

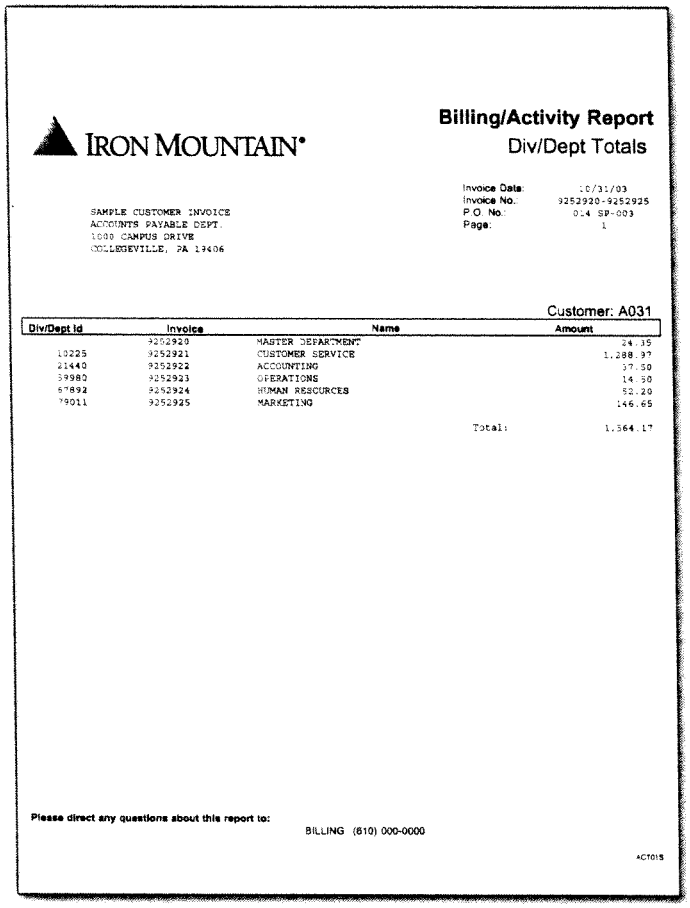
Transportation Handling – The per unit (e.g., cubic foot, carton, or package) service of prepping and loading the records onto and off of the Iron Mountain vehicle when making a pickup or delivery.

Trip Charge – The service of driving an Iron Mountain vehicle to and from the Customer's location for the purpose of delivering or picking up records.

Allocation of Charges by Division/Department

Allocation of service, supply, or storage charges by Division or Department is available to Customers upon request.

- For allocation of *service* and *supply* charges by ***Requestor***, a valid **DIVISION/DEPARTMENT** must accompany every order placed.
- For allocation of *service* and *storage* charges by ***Owner***, a ***Transmittal*** must accompany every carton and must contain a valid **DIVISION/DEPARTMENT**.
- All *service* or *storage* transactions that are **not** accompanied by a valid **DIVISION/DEPARTMENT** will be billed to the ***Master Department*** that has been set up for your account.



IRON MOUNTAIN®

Billing/Activity Report
Div/Dept Totals

Invoice Date: 10/31/03
Invoice No.: 9252920-9252925
P.O. No.: 014 SP-003
Page: 1

SAMPLE CUSTOMER INVOICE
ACCOUNTS PAYABLE DEPT.
1000 CAMPUS DRIVE
COLLEGEVILLE, PA 19406

Customer: A031

Div/Dept Id	Invoice	Name	Amount
	9252920	MASTER DEPARTMENT	24.35
10225	9252921	CUSTOMER SERVICE	1,288.97
21440	9252922	ACCOUNTING	37.50
59980	9252923	OPERATIONS	14.50
67892	9252924	HUMAN RESOURCES	52.20
79011	9252925	MARKETING	146.65
		Total:	1,564.17

Please direct any questions about this report to:
BILLING (610) 000-0000

AC7015

Invoice Levels

Customers may request to receive separate Invoices by Division or Department that can be mailed to different customer billing addresses or contacts. Combining multiple accounts into one Invoice is an option for Customers who have multiple accounts for operational purposes but would like to centralize and simplify their accounts payable function.

Invoice Reports

Your Invoice will be tailored to include the type of billing reports that are useful to operate and control costs within your organization. Available reports are:

- The ***Billing/Activity Report***, which lists a description of each type of transaction, the total quantity of each type of transaction, and the total amount. This report can be provided for multiple accounts, one customer account, each division, or each department, and is most useful for tracking the *service* and *storage* trends at various levels of your organization.

- The ***Totals Report***, which lists the total charges for all accounts, divisions, or departments within your organization. This report is most often used by Customers who choose to allocate billing charges internally by Division or Department.

- The ***Detail Billing Transaction Report***, which lists each order, the order date, requestor, quantity, description of service, rate, and amount. Customers can view this information online using the Iron Mountain Connect records management portal, or they can receive this report electronically via e-mail.

IRON MOUNTAIN
Detail Billing Transaction Report

Page: 1
Report Date: 10/28/03
Report Time: 10:02

Cust Id: A031 IRON MOUNTAIN RECORDS MANAGEMENT
Div Id: CUSTOMER SERVICE
Dept Id: 10225

Invoice Nbr: 9252921
Invoice Date: 10/31/2003

Ord Nbr	Ord Date	Bill Code	Tax	Desc	Date	Unit Qty	Uom	Nbr of Months	Rate	Amt
00000066	10/28/03	0890	NO	STORAGE, REGULAR	11/1/03	947.20	CF	1	0.280	265.22
00000066	10/28/03	1894	NO	STORAGE, LP	11/1/03	1400.00	EA	1	0.400	560.00
17616446	10/5/03	0122	NO	RETRIEVAL, CARTON		3.60	CF		2.500	9.00
		0211	NO	TRIP CHARGE		0.50	EA		35.000	17.50
		0220	NO	TRANSPORTATION HANDLING		3.65	CF		1.850	6.75
17616495	10/5/03	0211	NO	TRIP CHARGE		0.50	EA		35.000	17.50
		0220	NO	TRANSPORTATION HANDLING		2.00	CF		2.000	4.00
		1121	NO	OPEN SHELF RETRIEVAL		21.00	EA		1.000	21.00
17618436	10/8/03	0162	NO	REFILE		4.80	CF		2.500	12.00
		0216	NO	TRIP CHARGE, PICKUP		1.00	EA		35.000	35.00
		0220	NO	TRANSPORTATION HANDLING		4.80	CF		1.850	8.88
17619701	10/21/03	2041	NO	OFFSITE SHRED, SEC CONSOLE		4.00	EA		30.000	120.00
		2042	NO	OFFSITE SHRED, 65-GAL		2.00	EA		30.000	60.00
		2411	NO	OFFSITE SHRED, TRIP SCHEDULED		1.00	EA		0.000	0.00
17619865	10/25/03	0211	NO	TRIP		1.00	EA		35.000	35.00
		0220	NO	TRANSPORTATION HANDLING		24.00	CF		1.850	44.40
		0650	NO	RECEIVING AND ENTRY		24.00	CF		2.750	66.00
		0890	NO	STORAGE, NEW	10/25/03	24.00	CF	1	0.280	6.72

PENNSYLVANIA

Sub Total: 1,288.97
Sales Tax: 0.00
Invoice Amt: 1,288.97

********** End of Report **********

For more information about how to read your Invoice, selecting the appropriate invoice reports for your organization, or how to view your invoice reports via the Iron Mountain Connect records management portal, please contact your Iron Mountain Account Manager.

Quick Reference Card

*Please take a monment to complete the **Customer Quick Reference Card** with the information pertinent to your organization. The information contained in this document will be the information you will be asked when you contact Iron Mountain.*

IRON MOUNTAIN®

Customer Quick Reference Card

Check Service Type: ☐ **Records Management** ☐ **Shredding**

Customer Name: ***Customer #/ID:***
Division ID, if applicable: Department ID, if applicable:

Records Management/Shredding - *for Questions, Orders, Authorized User Updates:*

USA Customers
Iron Mountain Customer Response
1000 Campus Drive
Collegeville, PA 19426
Call 1 800 FASTFILE **Fax 1 800 934-5348**

Canadian Customers
Iron Mountain Customer Response
120 MacDonald Street
Saint John, NB E2J 1M5
Call 1 800 FASTFILE **Fax Canada: 1-800 387-0124**
Maritimes Fax: 1-800 316-2464

Local IM Mailing & Shipping Address
Iron Mountain – Location:
Street Address:
City: , State/Prov.: Zip/Postal Code:

Contacts
General Manager:
Customer Service Manager:
Local Office Phone#: Local Office Fax#:

Placing orders with Iron Mountain
Your IM Department ID
☐ is ☐ is not required when placing orders

General Reminders – All Customers

- Always make a note of your Order Number for your future reference
- Contact Customer Response as noted above for orders, address changes or authorized user changes.
- When faxing orders, make sure all information is complete, including Customer ID, Division/Department ID if applicable, Ship to Address, Contact Name, & Phone Number.

v. 11.15.06

Carton Quick Reference Guide

Information – today, it's the single most important asset your organization possesses. For more than 50 years, Iron Mountain has been the leader in records and information management services. That's why we take protecting and preserving your most valuable information very seriously.

One way to ensure the integrity of your organization's valuable information is to use storage cartons specifically designed for the job. Whether you store your information on-site, or with Iron Mountain off-site, we can provide you with a wide variety of cartons — each one manufactured to exacting standards, designed for ease of assembly and convenience, and tested for strength and durability.

Cartons Designed to Meet Your Needs

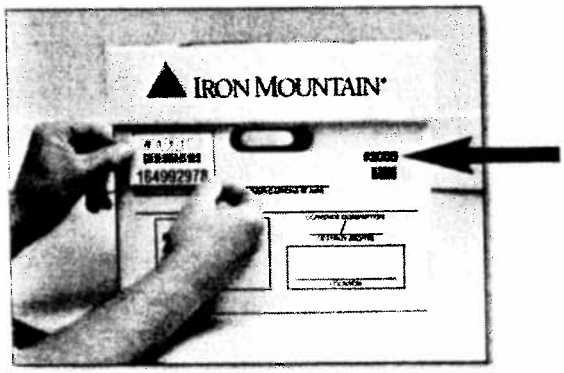
Records come in a wide variety of shapes, sizes, and mediums. To ensure that yours are adequately protected, Iron Mountain offers cartons designed to store such items as:

- Standard, letter-sized business documents
- Legal and oversized documents
- Medical records, x-rays, and ledgers
- Blueprints, architectural plans, and engineering drawings
- Business checks, deposit slips, and time cards
- Cassette tapes and videotapes
- Any other important document

All of Iron Mountain's cartons are environmentally friendly. They are composed of both virgin and recycled materials and are recyclable, as well.

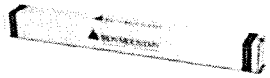
How to Order Iron Mountain Cartons

Ordering Iron Mountain cartons is easy! You can order online by using the Iron Mountain Connect™ records management portal, or by contacting us at 1 800 FastFile®. Regardless of the method, an Iron Mountain Representative will be happy to assist you. For more efficient ordering, please provide the carton model number, located on the hand-hold side of each carton.



When it comes to serving the document needs of your business, small or large, trust Iron Mountain.

Iron Mountain Standard Carton Inventory

	MODEL #	CARTON TYPE AND DESCRIPTION
15" L x 12" W x 10" H	2000	**Standard** (letter/legal) • Easy-to-assemble, sturdy, letter/legal storage solution • Double-ended construction • 200 lb. test corrugated
15" L x 12" W x 10" H	2000A	**Auto-fold** (letter/legal) • Pop-up assembly, durable, letter/legal storage solution • Double-walled construction • 200 lb. test corrugated
15" L x 12" W x 10" H	2750	**Deluxe** (letter/legal) • Durable enough to withstand the demands of frequent reference and retrieval • Triple-walled construction • 200 lb. test corrugated
24" L x 12" W x 10" H	450	**Letter Transfer** • Double the space capacity of the Standard carton, the Letter Transfer carton conveniently holds the contents of an entire file drawer • Double-walled construction • 200 lb. test corrugated
24" L x 15" W x 10" H	550	**Legal Transfer** • Larger storage capacity than our Standard carton in order to accommodate legal-sized documents • Double-walled construction • 200 lb. test corrugated
15" L x 6.25" W x 20" H	200	**X-ray** • Securely holds x-rays, ledger books and similarly sized documents upright and in order • Single-walled construction • 275 lb. test corrugated
 42" L x 4" W x 4" H	630	**Small Planner** • Convenient storage for rolled maps, blueprints, plans and drawings • Single-walled construction • 200 lb. test corrugated
44" L x 9.25" W x 9.25" H	632	**Large Planner** • Designed to hold the contents of four Small Planner cartons. Provides maximum storage capacity for rolled maps, blueprints, plans and drawings • Single-walled construction • 275 lb. test corrugated
24" L x 9" W x 4.5" H	844	**Check** • Convenient storage for all types of checks, deposit slips, time cards, cassette tapes, videotapes, and similarly sized documents • Double-walled construction • 200 lb. test corrugated

For more information about ordering cartons and supplies, please contact your Iron Mountain Account Manager.

Notes

Customer Handbook

IRON MOUNTAIN®
745 Atlantic Avenue
Boston, Massachusetts 02111
(800) 899-IRON

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For more information, visit our Web site at **www.ironmountain.com**.

US-RM-CR-200-06-001

IRON MOUNTAIN®

DATA SHEET

Completing the Transmittal Sheet/ Using the Barcode Label

Sending New Records to Iron Mountain Via the Transmittal Sheet

A Transmittal is the medium by which a carton's descriptive information is captured. Iron Mountain provides three types of Transmittals:

- The easy-to-complete, multi-carton Transmittal Sheet
- The easy-to-complete, one-carton-at-a-time Transmittal Form
- Online data entry by using the Iron Mountain Connect™ records management portal

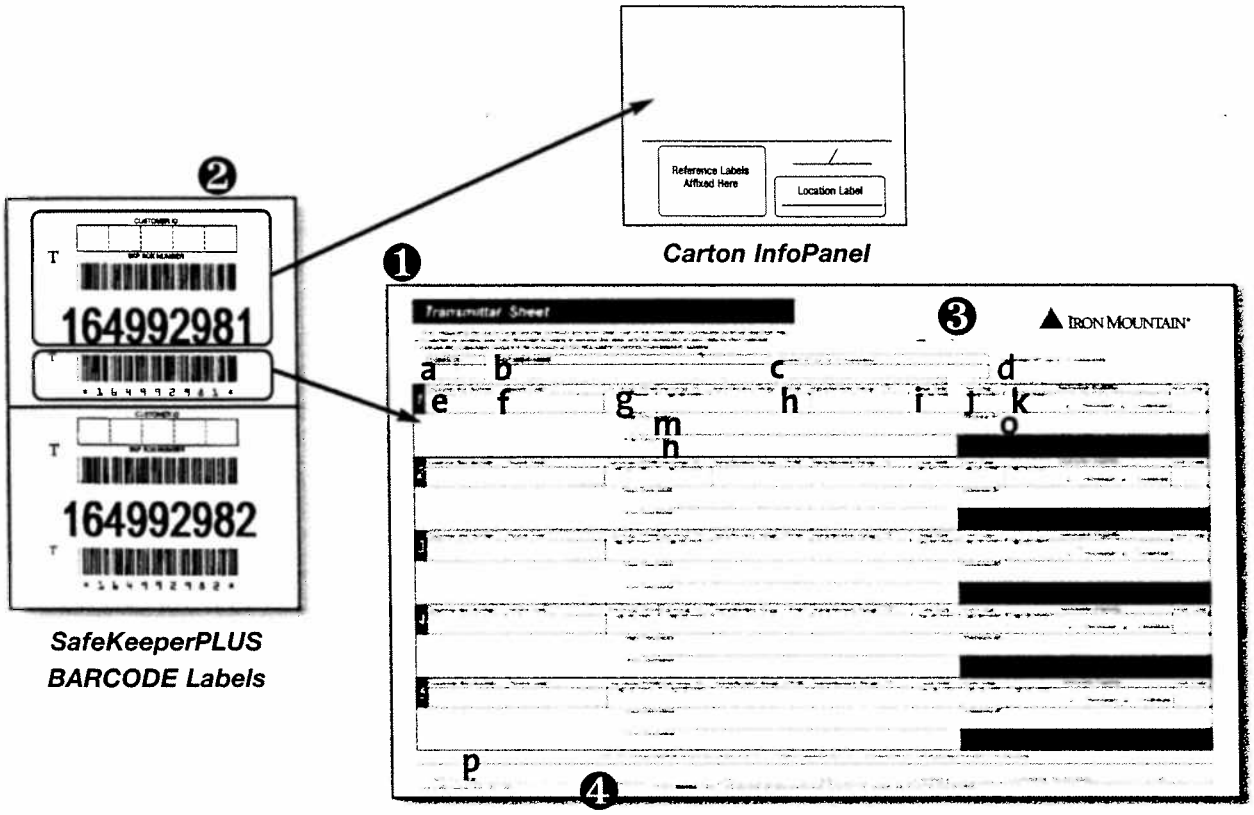
The Transmittal Sheet and Transmittal Form are off-line methods. The Transmittal Sheet accommodates the descriptive information for up to five cartons per Sheet. The Transmittal Form, in triplicate copy, accepts only one carton per Form. Online data entry is available in limited capacity to some Iron Mountain Connect users who are authorized to access the Inventory Maintenance menu. Contact your Iron Mountain Account Manager for more information about online data entry.

The method you use will depend on how your account is set up. Regardless of the method, however, all descriptive information that is captured is provided back to you via inventory reports generated by Iron Mountain.

The Transmittal Sheet

Complete one (1) Transmittal Sheet for each group of five (5) new cartons to be stored at Iron Mountain. Enter the correct information in the areas indicated, clearly and legibly printing all information. Begin all entries from the left side of each field except where noted. Please note that the Iron Mountain systems do not recognize leading zeros in the DIVISION ID, DEPARTMENT ID, and RECORD CODE fields. For example, Department 0001234 would be recognized as Department 1234.

CC701



❶ Complete the Transmittal Sheet by printing:

a. Your four- or five-digit CUSTOMER ID on both the Transmittal Sheet and large peel-off Barcode Label (this is a must).

b. Your CUSTOMER NAME.

c. The DIVISION ID* of the DEPARTMENT, using up to 12 alphanumeric characters.
*NOTE: Only customers specifically set up to use Divisions should utilize the DIVISION field.

d. The DEPARTMENT ID of the new cartons, using up to 10 alphanumeric characters*.
*NOTE: Only customers specifically set up to use extended Department IDs should use blocks 11 and 12.

e. The CUSTOMER BOX NUMBER for each carton. This field should only be completed if you specifically assign a carton number other than the SafeKeeperPLUS® (SKP) BARCODE NUMBER for your internal tracking purposes.

f. The RECORD CODE using up to 6 alphanumeric characters*.
*NOTE: Only customers specifically set up to use extended Record Codes should use blocks 7 through 10. If the RECORD CODE parameter is set to '1' or '2', then anything in the DESTROY DATE or DESTRUCTION INDICATOR will be ignored by the system and overridden by the RECORD CODE rules. Only if the parameter is set to '0' or '3', will the system consider these values.

g. The DATE RANGE/FROM and DATE RANGE/TO, which are the oldest and most recent dates of the records contained in the carton. Retention can be calculated from these dates. Only valid dates including month, day and year are acceptable here.

h. The ALPHA/NUMERIC RANGE-FROM and ALPHA/NUMERIC RANGE-TO, which are the beginning and ending alphabetical/numerical ranges of the records contained in the carton. The FROM and TO Alpha/Numeric Range fields can be used to describe a name range (Jones through Smith), a numeric "file id" range (20450 through 20567), or an alphanumeric "file id" range (AD123 through BZ784).

i. The CREATE DATE, which is the date that the materials were packaged and labeled for storage; or, the date that the records were actually created. Retention can be calculated from these dates. Only a valid date including month, day and year is acceptable here.

j. The EVENT DATE, which is the date of the event that the contents of the carton contains, if applicable. Retention can be calculated from this date. Only a valid date including month, day and year is acceptable here.

k. The DESTRUCTION ELIGIBILITY, identifies when a carton is scheduled for destruction. Leave this section blank, if your organization establishes DESTRUCTION ELIGIBILITY using RECORD CODES. If your organization does not use RECORD CODES to determine when a carton is eligible for destruction, enter either a valid Destruction Date, (month/day/year) or check one of the DESTRUCTION INDICATORS: Permanent or Undefined.

NOTE: Nothing will be destroyed automatically. A letter of authorization from your organization is required for destruction.

l. The HOLD CODE for each carton, extends the RETENTION PERIOD of a carton. HOLD CODES must be setup on the system prior to use. If records should be retained permanently, select the check box under DESTRUCTION ELIGIBILITY.

m. The MAJOR DESCRIPTION of the contents of the carton as it is to appear on the Inventory Reports provided by Iron Mountain.

Example: ALE - AMA or 100 - 999 (numeric or alpha ranges must be separated with a dash).

Example: CORRESPONDENCE (complete descriptions may be spelled out).

NOTE: To keep numeric ranges in the proper sort sequence and to maintain an orderly listing, the dash '-' should be placed to the right of the heavy vertical line; fields should be zero-filled where necessary.

```
| | | |0|0|1|2|5|-|0|0|1|8|5| | | | |
| | | |1|2|0|5|0|-|1|2|1|7|5| | | | |
```

If the files within the carton will be individually listed, print the phase "Individual List" in the MAJOR DESCRIPTION field. If you have previously filled out a Division/Department Form, clearly establishing RECORD CODES for each RECORD CODE TITLE, then a MAJOR DESCRIPTION is not necessary.

n. Print additional MINOR DESCRIPTION information as it is to appear on your Inventory Reports (follow the instructions for MAJOR DESCRIPTION).

o. The REFERENCE #1 field, which is a miscellaneous, alphanumeric field used for additional cross-reference information about the carton.

p. Your name in the PREPARER'S FULL NAME field, as well as the DATE, your DIVISION ID, DEPARTMENT ID, TELEPHONE NUMBER and EXTENSION, and FLOOR. At the top of the Sheet, be sure to number the pages in sequence, starting with "Page 1".

❷ Place the large peel-off Barcode Label on the carton's InfoPanel in the area marked 'Affix Transmittal Label Here' on one of the handhold sides. Make sure your Customer ID is also displayed on the Label.

Place the smaller, identically numbered Barcode Label on the Transmittal Sheet in the area marked 'Place the SafeKeeperPLUS® Barcode Label (T-Label) Here'.

❸ Once you have completed all of the Transmittal Sheets for this group of cartons you are sending, count the total number of Sheets and place this total number on all of the Sheets in the space marked "Page _____ of _____". Staple the Sheets together, in order.

❹ Have the originals ready for the driver to pick up with the new cartons. Make photocopies of the Transmittal Sheets for your records.

❺ Verify that the physical carton count matches the itemization on the Transmittal Sheets.

❻ Contact Iron Mountain to schedule a pickup.

*NOTE: To ensure the accuracy and integrity of your inventory requirements, please review all information listed on the transmittal document to ensure it is complete, accurate and legible, and the document has not been folded or torn before it is submitted to Iron Mountain.

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IRON MOUNTAIN®
745 Atlantic Avenue
Boston, Massachusetts 02111
1-800-FastFile

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Iron Mountain Connect™

User Guide

IRON MOUNTAIN®

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Document Information

Iron Mountain Connect™ User Guide

Printed April 2007

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Module One: Iron Mountain Connect™ Overview

The Iron Mountain Connect system is designed to access and maintain records management information that is managed through Iron Mountain. The system provides secure, easy, quick, online access to records and information.

The Iron Mountain Connect application was developed to make it easy to search for information and place orders within one system.

In addition, Iron Mountain looked at matching its system with some of the drivers in the marketplace. It relates to what an organization might need to do while developing a comprehensive records management program.

Much of the functionality is based on "The Four Pillars of Records Management." The four pillars are guidelines that consist of components of developing and maintaining a compliant records management program in cooperation with current laws and regulations, along with individual company policies and procedures.

The Four Pillars of Records Management:

- **Consistency**: All of your information, across your departments, divisions, and/or business lines can be maintained in one system. All of your information can be classified or indexed the same way every time.

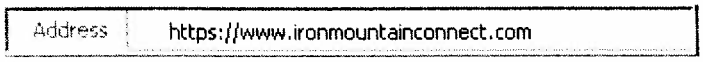
- **Accountability**: Access to use the Iron Mountain Connect system is provided to an entire customer organization if requested. The application can be an extension of your internal website. The ability to post documents, communications, and policies and procedures all in one location, gives companies the access needed to learn and review the information that they are held accountable and responsible for.

- **Adoption**: The ease of use in the Iron Mountain Connect system makes the adoption of a program feasible across all levels of an organization. The system has been designed with self-service features that will encourage users to want to use it.

- **Access:** All information is gathered in one place to meet the need of accessibility. The option to search for, request and run reports on information can be conducted with just a few clicks. The site is secure so only those needing to have access to the system will be allowed.

Accessing Iron Mountain Connect

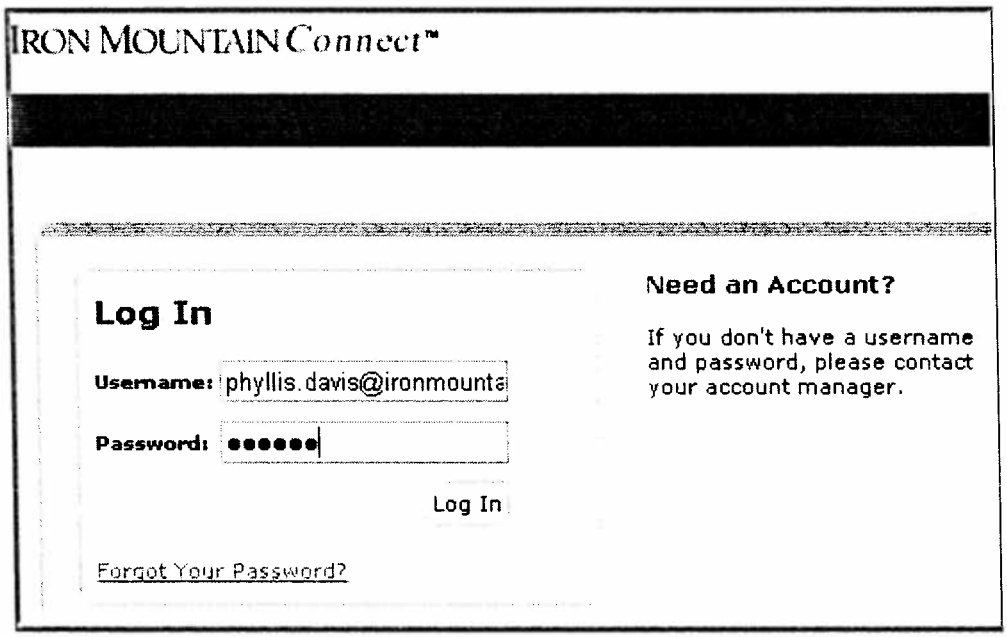
1. In your browser, type www.ironmountainconnect.com, and click Enter:



2. On the login page, enter your username and password.

3. Click Login

Note: Your Iron Mountain Account Manager will provide your new username and password. If you do not have an Account Manager, contact Iron Mountain and they will provide your username and password. You may not have duplicate email addresses in the system.



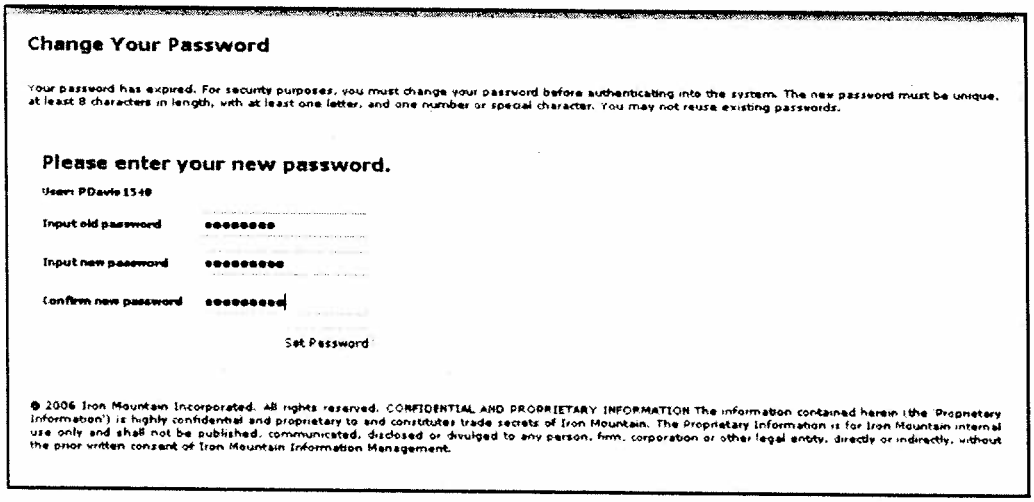
The system displays "Iron Mountain Connect" homepage.

Initial Sign On

The first time you sign on as a new user, you will need to change the password generated by the system.

Passwords must meet the following criteria:

- At least 8 characters long
- Contain at least one letter and
- Contain at least one number or special character
- Cannot have been used previously



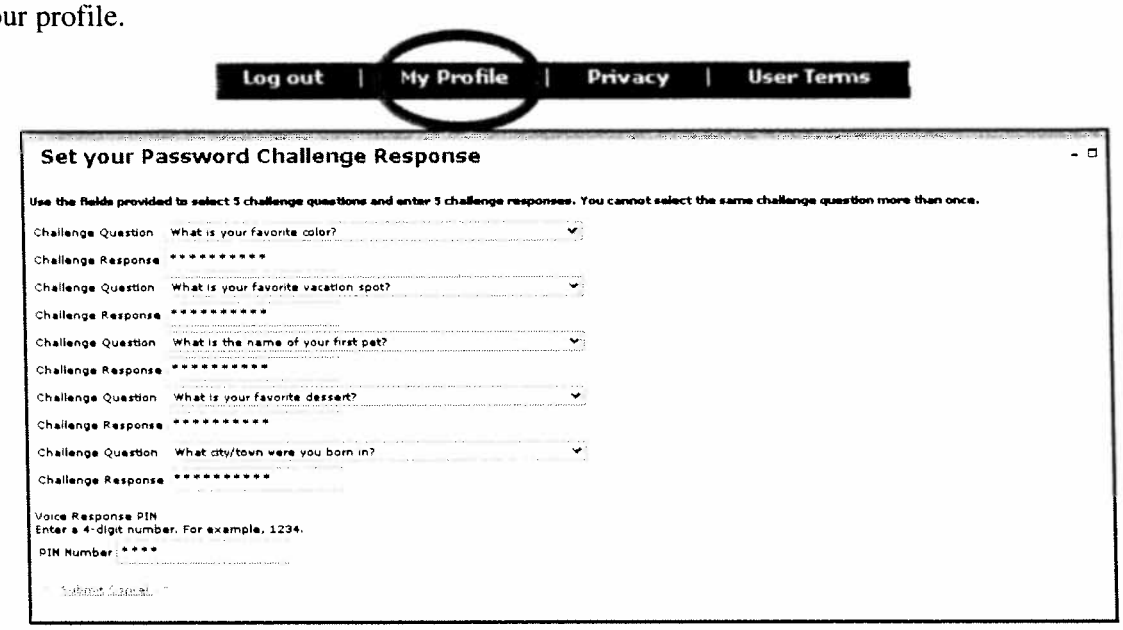
You will also need to set up security/challenge questions. These questions are used if you forget your password or have locked yourself out of the system with three unsuccessful attempts to enter your password.

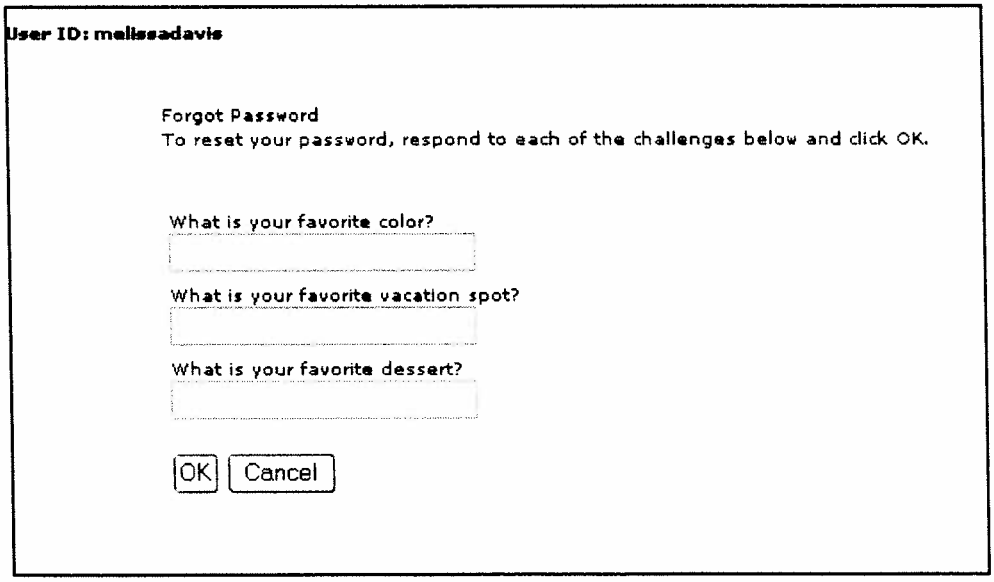
You will need to select five challenge questions (out of 10 available questions) and enter your answers. If you need to use the Forgot Password function, the system will randomly select three of the five questions for you to answer.

All three questions must be answered correctly and you have three attempts before being locked out of the system.

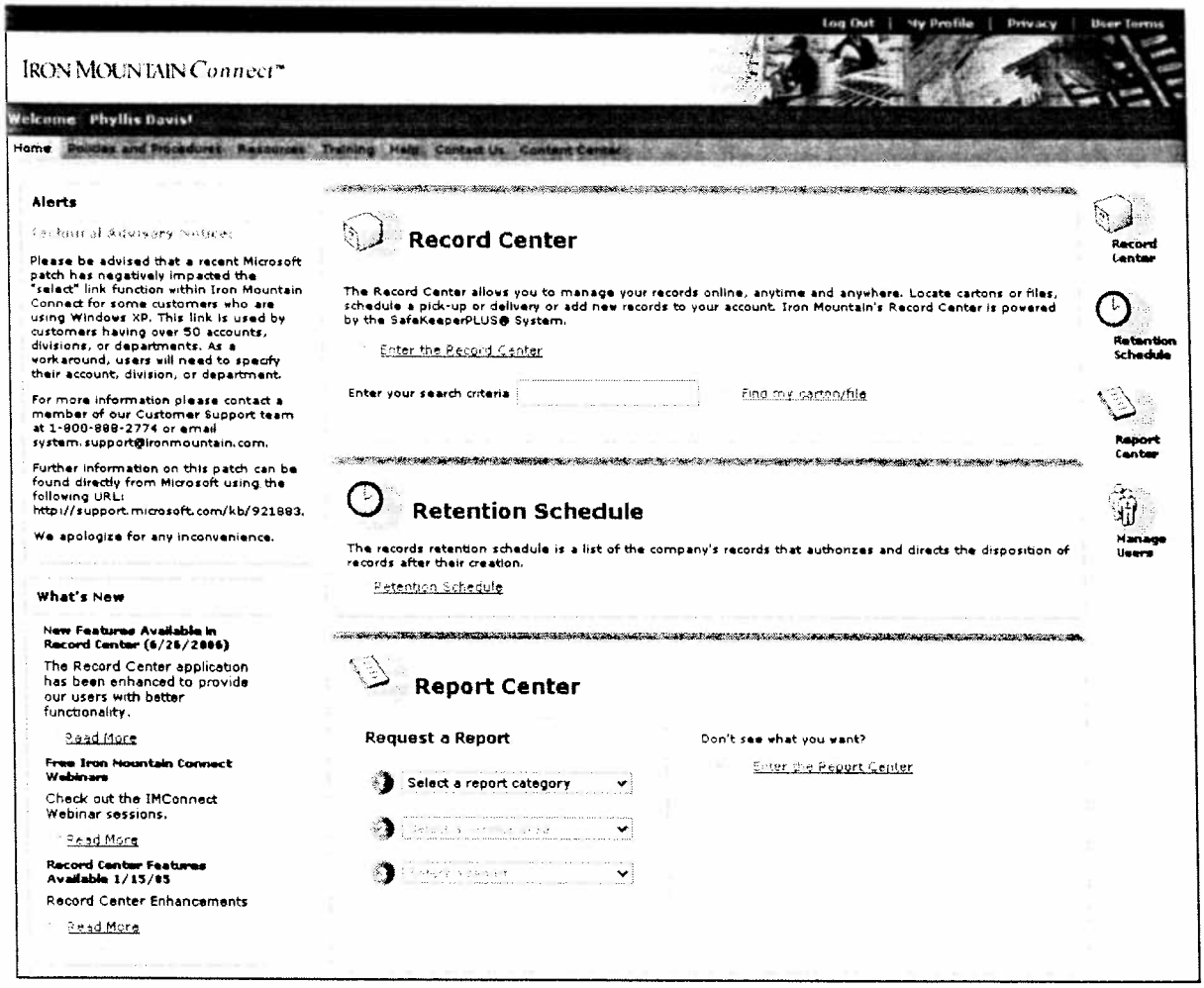
In addition, you will need to set up a voice response PIN number.

You can modify the selected questions and answers by clicking on the My Profile link along the top menu bar. The password and challenge question links are located under the username field of your profile.





Iron Mountain Connect™ Homepage



The Iron Mountain Connect Homepage gives you access to the following components of the system:

- **The Record Center**: Is powered by SafeKeeperPLUS.Com®, and is the transactional center of Iron Mountain Connect. Customers can easily locate cartons or files, search for records, and schedule pick-ups all in one convenient location.

- **Manage Users**: This section allows customers to edit and add new user profiles to their company list. Only those set up as Administrators have access to this component.

- **The Report Center**: Enables customers to monitor their records management practices to ensure the ongoing quality of the program. Audit and compliance reports can be run on Inventory, Financial, Retention, and Activity data.

- **Policies and Procedures**: Find helpful information to facilitate legal and regulatory compliance, security, and cost-effective access to records.

- **Resources and Training**: You can obtain Records Management 101 training, tips and best practices. Access to Flash Demos and User Guides are available from this area on Iron Mountain Connect.

- **Help**: You can find answers to your most frequently asked questions about Iron Mountain Connect and guidance in using the system.

- **Contact Us**: Provides information on how to contact Iron Mountain 24 hours a day, 7 days a week.

- **What's New**: Notifies you of any information that will be important regarding Iron Mountain Connect, along with any enhancements that have taken place in the system.

- **Content Center**: The content center provides an area where your company's logo can be uploaded to the site to customize the look of Iron Mountain Connect. Only those with administrator access will be able to utilize the functionality of the Content Center.

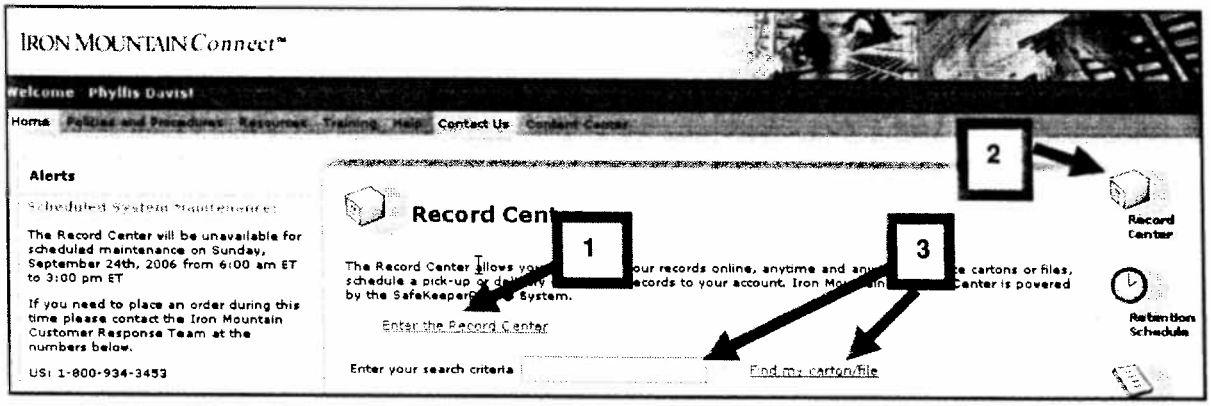
Note: Custom content can be uploaded in many of the application portlets such as Policies and Procedures by administrators with the proper authorization.

Accessing the Record Center

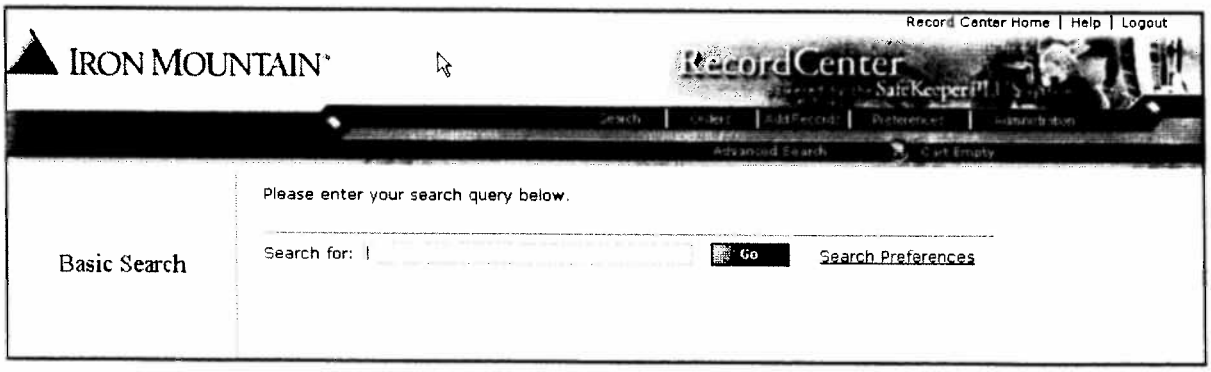
The Record Center, powered by the SafeKeeperPLUS® system, is where you perform your online activities with Iron Mountain. The Record Center is simply an extension of SafeKeeperPLUS®, our internal system. Depending on their individual access levels, when users in your company access your account in the Record Center, they are able to search, view, retrieve, and schedule orders for your company's records.

There are three different ways to access the Record Center. Type or click one of the following to access the Record Center:

1. Click Enter the Record Center link
2. Click Record Center icon
3. Enter Search criteria or click Find my carton/file hyperlink



Clicking on any of these options opens a separate window for doing a Basic Search in the Records Center.



Module Two: Searching in the Records Center

Searching in the Record Center

The search function lets you locate information from your inventory. You can locate information for the following:

Boxes

Files

Note: you can search across all of your accounts.

There are three types of search functions in the Record Center:

1. A "Basic Search" lets you type in search criteria for a broad search across your inventory. For example, you may want to look for records associated with the term "mortgage." By completing a basic search, Iron Mountain Connect pulls all files and boxes that include the word "mortgage." This may produce numerous results that you can select from.

2. An "Advanced Search" enables you to filter and refine your search based on selected criteria. There are over 55 types of criteria you can choose from to search for your information. For example, if you are an individually listed customer (a customer whose records at Iron Mountain contain information at the individual file level) you may want to look for a specific file with the name "Elm" in the title. For example, you can do the following:

- Search only "files" (as opposed to boxes)
- Search for titles = "Elm"

By completing an advanced search, the Iron Mountain Connect system pulls only the files with the name "Elm" in the title. By using these criteria filters, Iron Mountain Connect produces fewer search results to make it easier for you to find your information.

3. The "Last Search" Results will display the last search that you completed. This may be helpful if you continue to pull the same files and/or boxes from your inventory multiple times. By using the Last Search Results, Iron Mountain Connect pulls only the exact information that you obtained the last time you searched in the system to help save time.

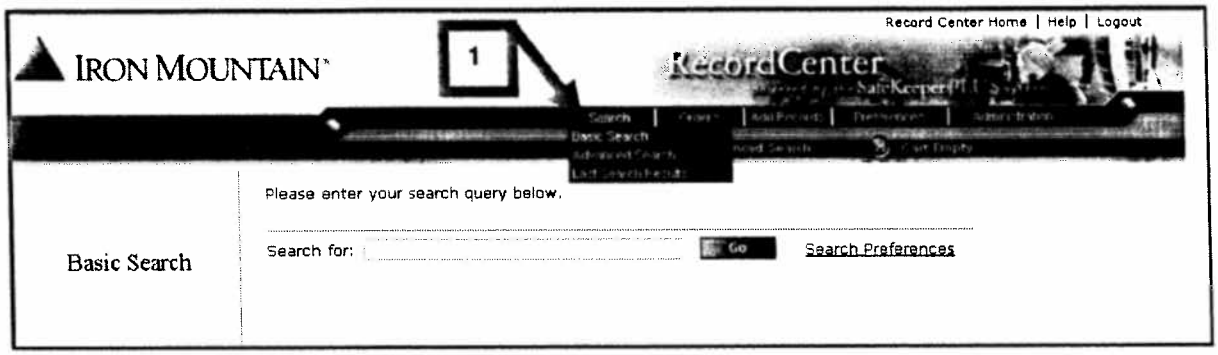
All search types are available from the Search menu, located on the navigation toolbar.

Performing a Basic Search

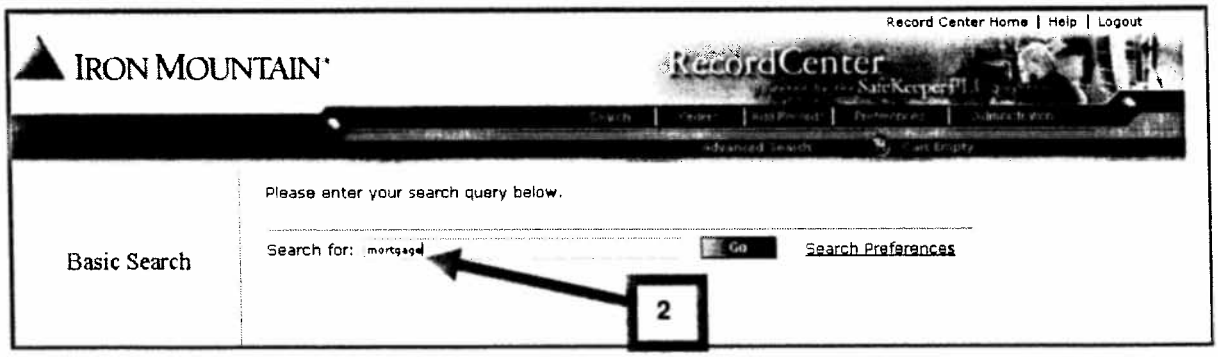
The "Basic Search" function lets you search across all inventory maintained at Iron Mountain. This includes your boxes and files and associated customer account numbers.

To perform a basic search, complete the following steps:

1. From the Search menu, select Basic Search:



2. Type your search criteria/key word (e.g., mortgage) and click Go.



In the above example, Iron Mountain Connect searches for the word mortgage across the entire inventory in the given account. All files and boxes that include the word mortgage and any criteria that is identifiable in the inventory stored in the Iron Mountain are displayed.

The screen shot below illustrates the search results for the word "mortgage." The speed of the search depends on the amount of inventory stored in your account at Iron Mountain.

The results are returned in a timeframe similar to Internet search engines (e.g., Yahoo, Google).

Search Results

Please enter your search query below.

Search for: mortgage Go Search Preferences

☐ Search within results

Create Search Results Report

1-4 of 4 records containing **mortgage**

☐ Select All Add All to Cart

3 1

	Status	Action
☐ **ELM STREET MORTGAGE CAPITAL LLC** Customer: ADEMO Law Client Name: ELM STREET **MORTGAGE** CAPITAL LLC Client Number: 19898 Matter Number: 005 Matter Description: INTOWN BANK CREDIT ENHANCEMENT Contained in: 90000000076	At Iron Mountain	Add to Cart Instant Checkout Edit Instructions
☐ **907** Customer: ADEMO Cost Center Code: LOAN Record Code: 234 Major Description: **MORTGAGE** RECORDS Minor Description: EQUITY Long Description1: ALL **MORTGAGE** FILES FOR 2005 YEAR FROM JONES TO MARY, STARTING WITH JANUARY AND ENDING IN JULY	At Iron Mountain	Add to Cart Instant Checkout Request Unlisted File Edit Instructions

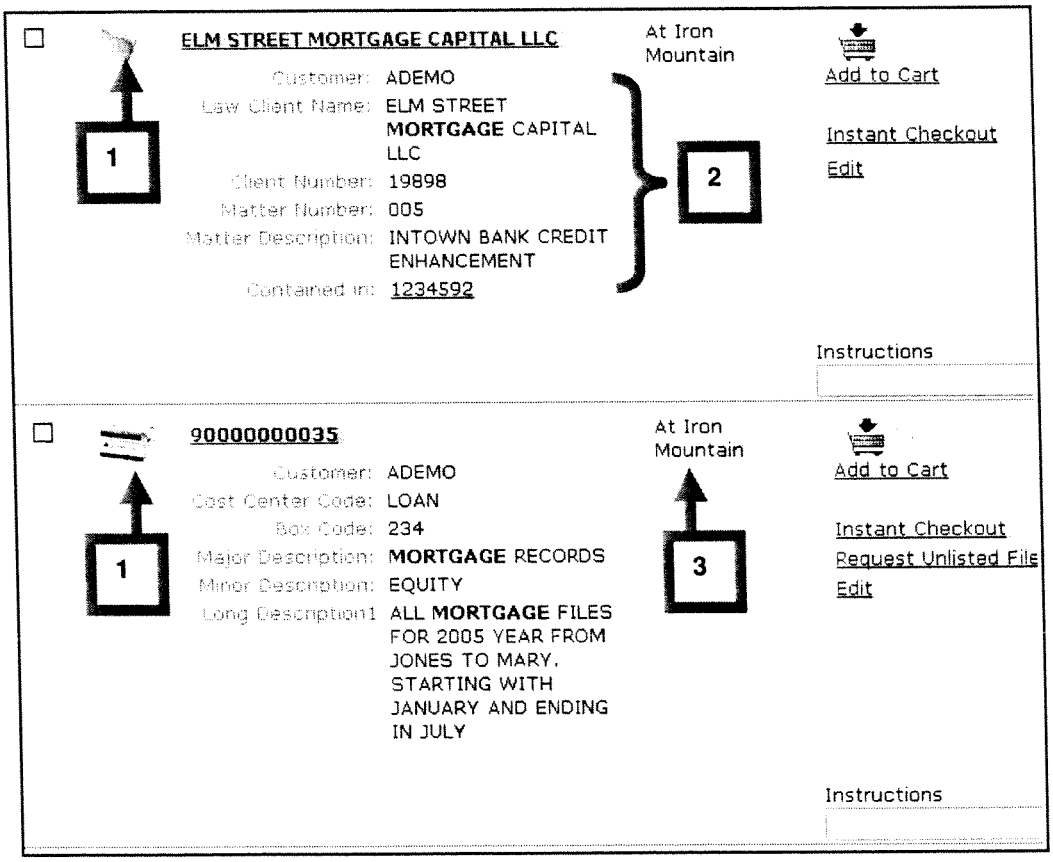
You can use any of the following options in a Basic Search:

- Keywords
- Box number
- File number
- Portions of a word
- Portions of a box/file number

Basic Search Results Details

In the screen shot below, you can see various places where the word "mortgage" is found in the record center (law client name field, major description field, etc.). In addition, the following information is displayed:

1. Whether the information is in a file or a box
2. General information about the file or box stored in the SafeKeeperPLUS system
3. Current location or status of the box



Additional Basic Search Options: Wildcard Search

There are times when you may not know the entire word that you are searching for or you may only know a part of the first or last name that you are searching for.

Iron Mountain Connect provides you with the ability to complete a "wildcard" search. A "wildcard" search allows you to type letters in the word search followed by an asterisk (*). The asterisk is used at the end of the string only.

There are two different types of combinations that you can use to perform a "wildcard" search:

1. First, you can enter MAR* in the "Search for" box and Iron Mountain Connect returns results with any words that begin with the letter MAR in any of the fields available in the system.

2. Second, you can enter multiple words with asterisks for a combination search. For example, enter MAR* and SMI* in the "Search for" box:

It is important to note that "and" is considered an ignored common word. In other words, your search only displays words beginning with MAR and SMI and disregards the word "and."

Similar to the above, you can retrieve the same results for MAR and SMI by typing it as follows in the "Search for" box:

MAR* SMI*	MAR*, SMI*	Your search disregards the space and comma between MAR* and SMI*

Additional Basic Search Options: Complex Queries

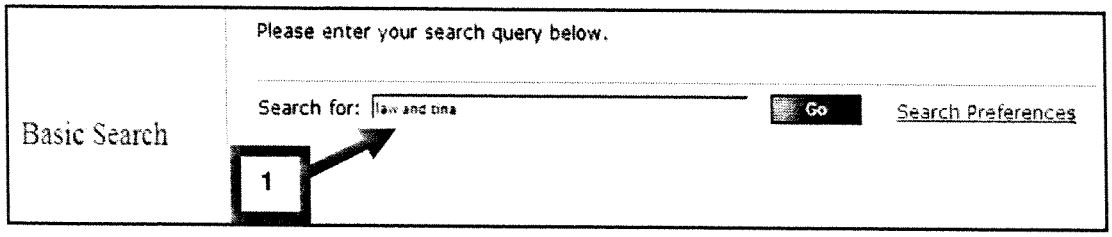
See the chart below for options to create more complex queries.

Desired Outcome	Operator Word/Symbol	Example Query	Results Produced
You do not want to see a certain word associated with another word	not	john not smith	All returns with the word john, except for those associated with smith
You want to see a grouping of results to match a specific word	( ) * use parentheses	john (smith, jones)	All returns with the word john and only with the associated words of smith or jones
You want to see an exact phrase	" " * use quotes	"john smith file"	All returns with the exact phrase john smith file
You want to see something "not shown"	- word * use the minus sign then the word	smith, -john	All returns with the word smith, except for those with john associations (make sure you leave a space after the comma)

Detailed Information from Basic Search

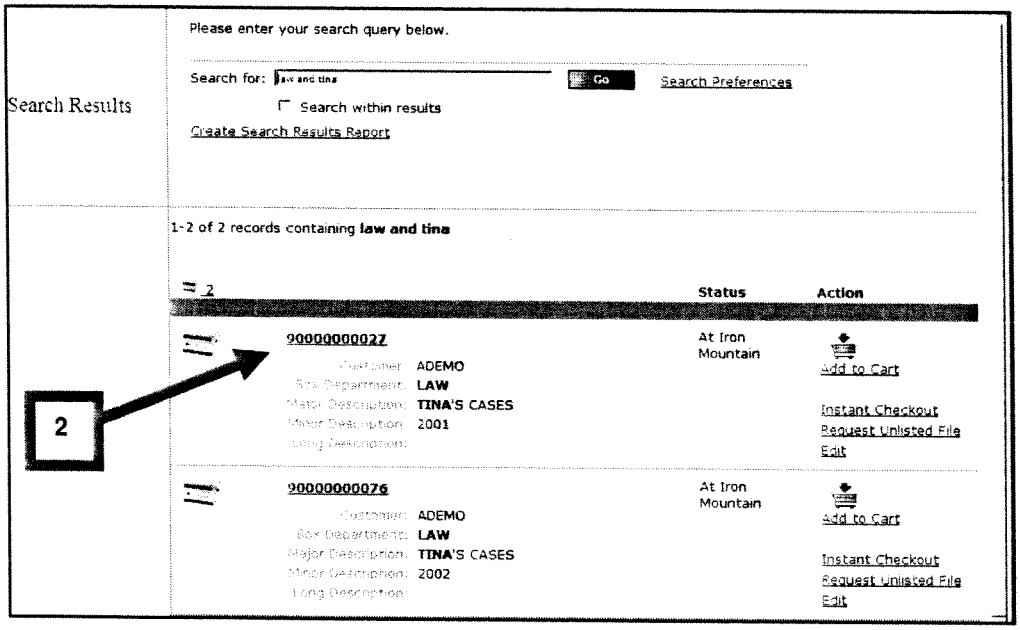
The following is another example of a basic search. In this example, you're looking for a box that contains law files and the name is Tina:

1. Type law and tina and click Go.



Search results displays two boxes for the words "law and tina."

2. Click on the box number and the system will display Box Details.



Box Details lists any specific descriptions entered, the receipt date at Iron Mountain, and the size of the box.

For customers who individually list their files, the details will also contain the amount of files listed within the box.

In this example, there are 10 files.

3. Click the Contents hyperlink to view additional details.

Box Details

Box: 90000000076
Status: At Iron Mountain

Detail

Customer: ADEMO [IMRM DEMO ACCOUNT (II)]
Box Department: LAW [LEGAL]
Box Record Code:
On Hold: Yes
Contents: 10 files

Actions

Add to Cart
Instant Checkout
Request Unlisted File
Edit
View History

3

Description

SKP Box Number: 90000000076
Customer Box Number: 1234592
Reference #1:
Reference #2:
Major Description: TINA'S CASES
Minor Description: 2002
From/To Date: 09/01/1993 - 10/31/1993
From/To Alphanumeric:
Create Date:
Event Date:
Receipt Date: 04/15/1994
Transmittal Received: Yes
Special File Format: LAW
Box Storage Size: 1.2

Long Description

Retention

Destruction Date: 12/31/2000
Destruction Indicator:

The system displays additional information for each of the 10 files contained within that box.

1-10 of 10 records searched

with SKP Box Number Contains **90000000076**
with Record Type Equals **File**

10	Status	Action
001 Customer: ADEMO Law Client Name: ENGLAND, ROBERTS & ALBION, P.C. Client Number: 27057 Matter Number: 001 Matter Description: JACKSON MOSS ROBERTS & CO Contained in: 90000000076	At Iron Mountain	Add to Cart Instant Checkout Edit
1143 Customer: ADEMO Law Client Name: FIRST INDUSTRIAL INSURANCE Client Number: 11124 Matter Number: 1143 Matter Description: ADAMS VS PINE Contained in: 90000000076	At Iron Mountain	Add to Cart Instant Checkout Edit
010	At Iron Mountain	

You can click any of the following Actions for either files or boxes:

- Add to Cart
- Instant Checkout
- Edit (depending on privileges granted)

See **Module 3: Ordering in the Records Center** for information about ordering.

Basic Search Results Review

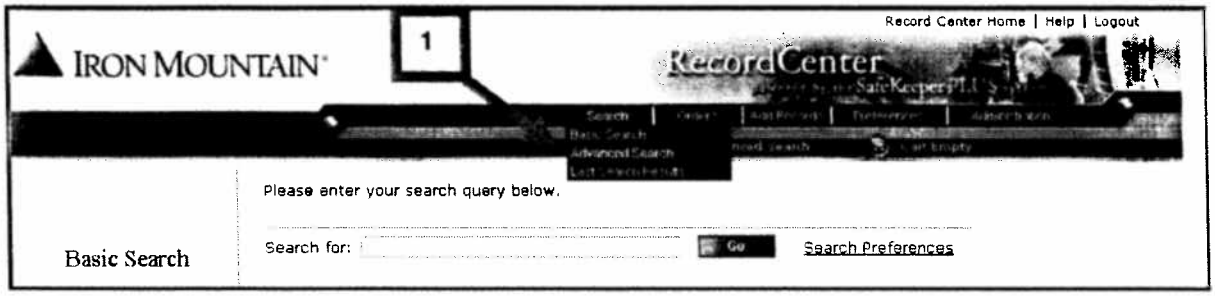
- "Basic Search" is a broad search across all inventory maintained at Iron Mountain. It includes your files, boxes, and account numbers.
- "Basic Search" works similarly to an Internet search engine (e.g., Google, Yahoo). The search is not case-sensitive: you may use lowercase and/or uppercase letters. The system only finds whole words. For example, it does not return results in which "law" is embedded in another word as in the word "lawson."
- The "wildcard" search lets you search on the first few characters of a field if you're unsure of the exact spelling or the entire word.
- "Basic Search" returns up to 2,500 results based on the criteria or key word submitted.
- Iron Mountain Connect can handle complex queries which include or exclude certain words and/or numbers together.
- The search results are gathered based on a relevancy ranking to the criteria or key word entered. The relevancy ranking is based on the following three key factors:
    - Word Score = frequency of the key word (criteria) in the results
    - Asset Age = receipt date from SafeKeeperPLUS
    - Request count = number of times the asset has been ordered
- The Record Center supports the Open Shelf environment. This lets you utilize open shelf for your files that are individually listed in the SafeKeeperPLUS system, to be found through standard searching.
- Any unlisted files can be found and created as a temp file for retrieval.

Performing an Advanced Search

Advanced Search is a more refined search. It allows you to search across all inventory associated with a customer's account number(s). Advanced Search lets you filter your search based on selected criteria.

To perform an Advanced Search:

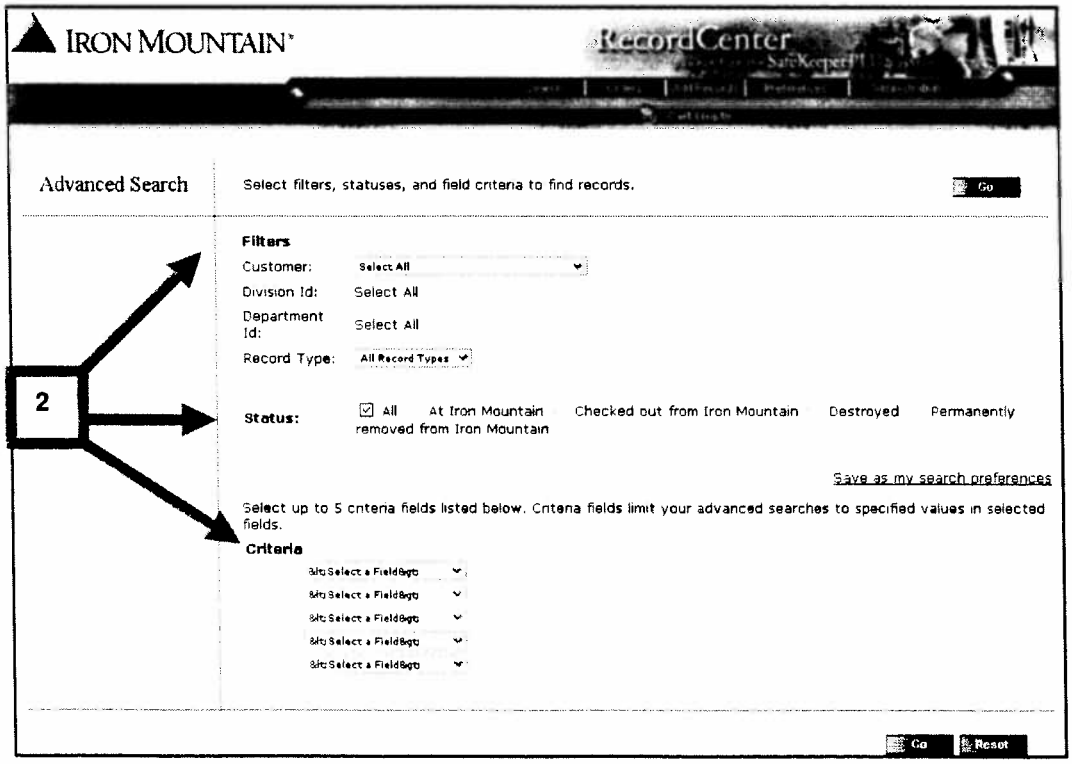
1. From the Search drop down menu, select Advanced Search:



The system displays the Advanced Search screen.

2. Enter the Search criteria.

The Advanced Search screen provides you with additional options to narrow your returned results: designating Filters, indicating item Status and setting selection Criteria.



Filter Selections:

- Selection of the Customer ID or Account from the drop down menu
- Selection of the Division and/or Department
- Selection of Record Type

Status Selections:

- All
- At Iron Mountain
- Checked Out From Iron Mountain
- Destroyed
- Permanently Removed From Iron Mountain

Criteria Selections:

- You can select up to five (5) search criteria.

Search Criteria

Any field	Description 2	Loan Number
Accounting Client Name	Description 3	Long Description
Acquisition Code	Description 4	Loss Date
Alpha Test Range	Destruction Indicator	Major Description
Birth Date	Discharge Date	Matter Description
Borrower Name	Division ID	Matter Number
Box Destruction Date	Entry Year	Matter Sub Number
Box From Date	Event Date	Minor Description
Box To Date	Field Description (1-4)	Office
Box Owner	File Destruction Date	Office Number
Claim/Policy Indicator	File From Date	Old Loan Number
Claim/Policy Number	File Sequence Number	Patient Birth Date
Claimant Insured Name	File To Date	Patient Number
Claimant Name	First Name	Receipt Date
Client Number	Insured Name	Record Code
Cost Center	Last Name	Reference Number 1

Create Date	Law Client Name	Reference Number 2
Customer Box Number	Law Close Date	SKP Box Number
Date Range	Law Letter Code	Social Security Number
Department	Lawyer 1	Symbol
Description 1	Lawyer 2	Volume Number

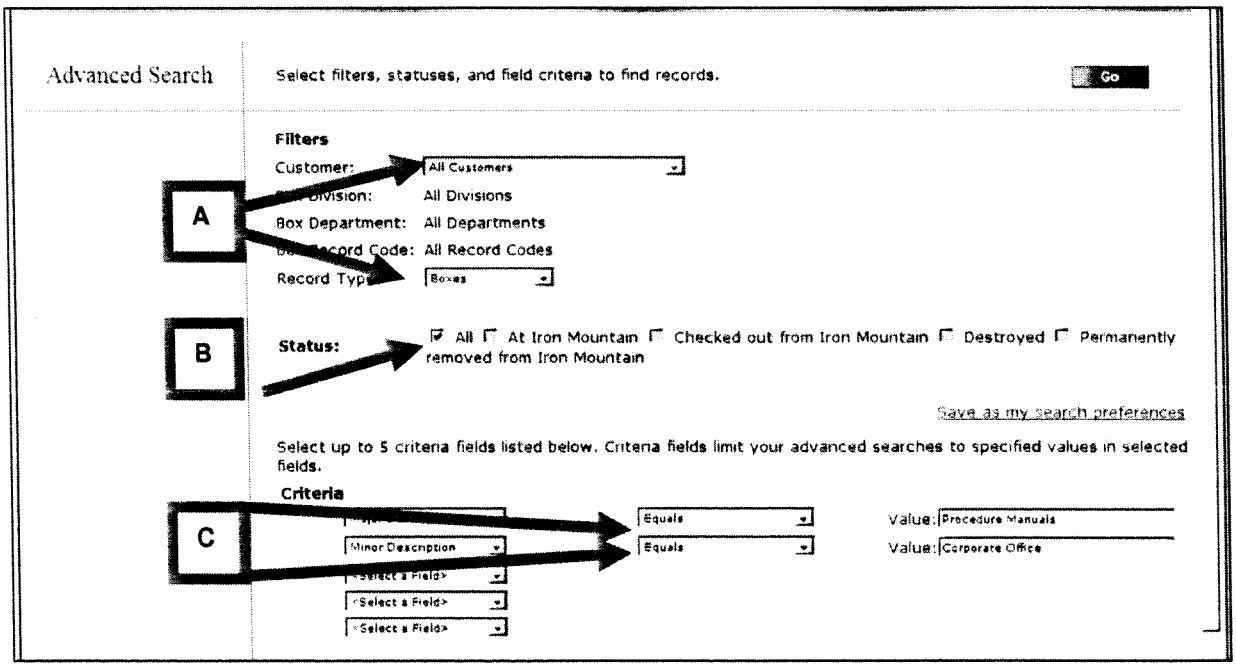
The following is an example of an Advanced Search:

A. Filters - All Customers and Boxes are selected

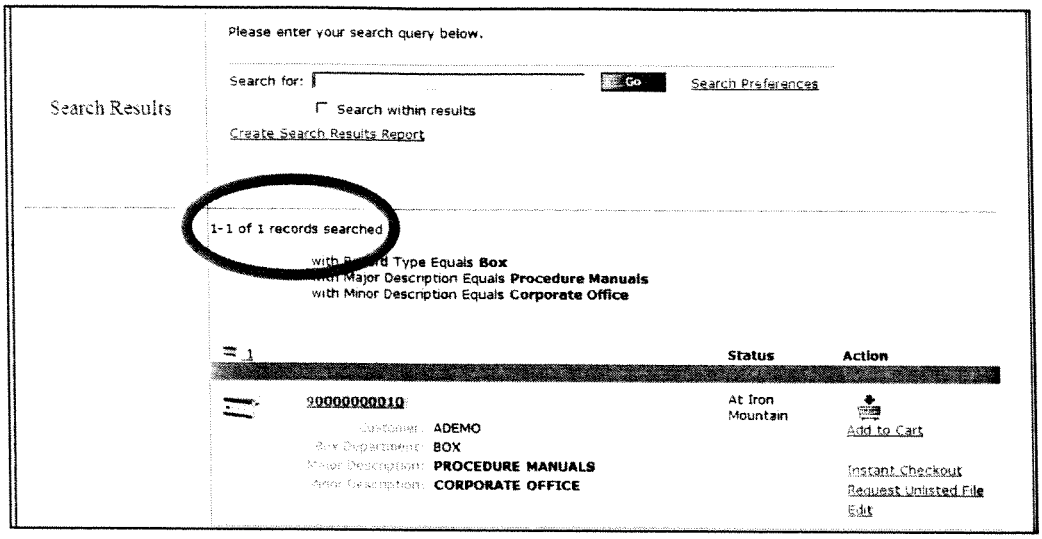
B. Status - All is selected

C. Criteria - Major Description is selected with a value of Procedure Manuals

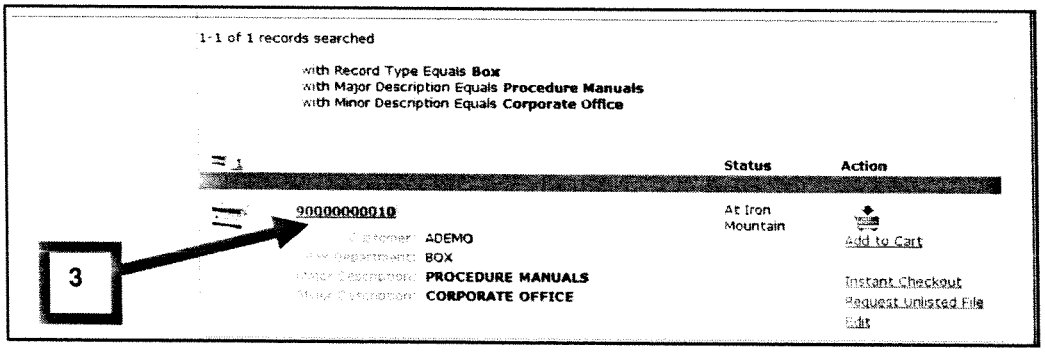
Minor Description is selected with a value of Corporate Office



The search returned only one item matching all the selection options.

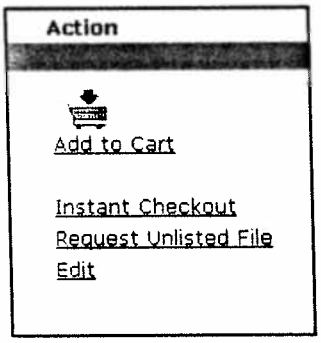


3. Review the box or file details by clicking on the highlighted box and/or file number hyperlink:



4. You can select any of the following Actions:

- Add to Cart
- Instant Checkout
- Edit (depending on privileges granted)



Advanced Search Results Review

- Advanced Search is a refined search across all inventory maintained at Iron Mountain for a given customer and its associated customer account numbers.
- Advanced Search lets you select certain filters, status, and criteria to narrow your search results.
- There are more than 55 types of selection criteria. You can use up to 5 selection criteria options for each advanced search.
- The Record Center supports the Open Shelf environment. This lets you utilize open shelf for your files that are listed in SafeKeeperPLUS, to be found through standard searching. Any unlisted files can be found and created as a temp file for retrieval.

Last Search Results

Last Search Results lets you pull up search results from your last search conducted while logged into that session.

Module Three: Placing Orders in the Record Center

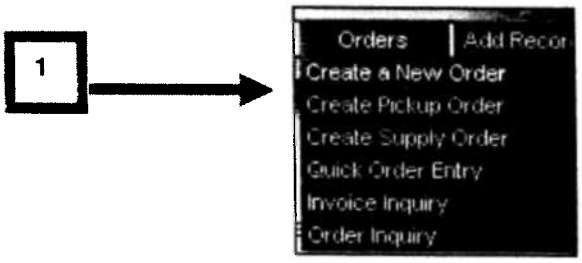
Ordering

There are six different Order options.

- Creating a New Order (for retrieval from Iron Mountain)
- Creating a Pickup Order (to send files or boxes to Iron Mountain)
- Creating a Supply Order (for delivery)
- Creating a Quick Order (fewer screens for ordering)
- Invoice Inquiry (read only inquiries)
- Order Inquiry (read only inquiries)

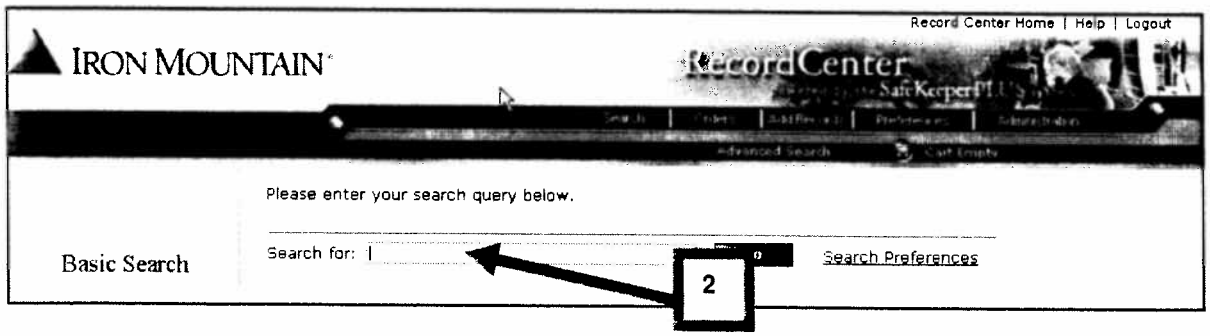
Create a New Order

1. Click Orders and select Create a New Order.

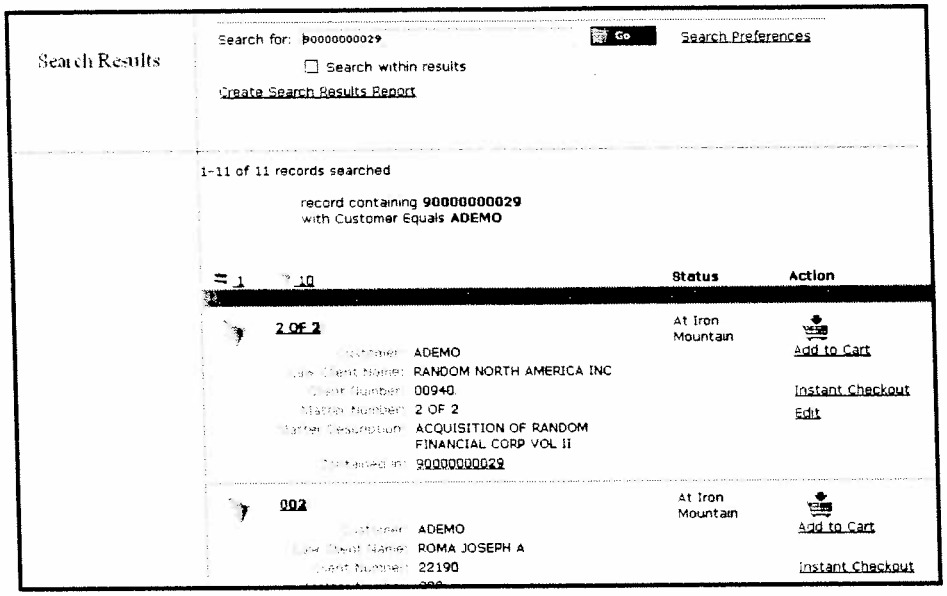


The system displays the Basic Search screen.

2. Enter the search criteria (box/file number, etc.) in the Search for box and click Go:



The system displays the Search Results screen.



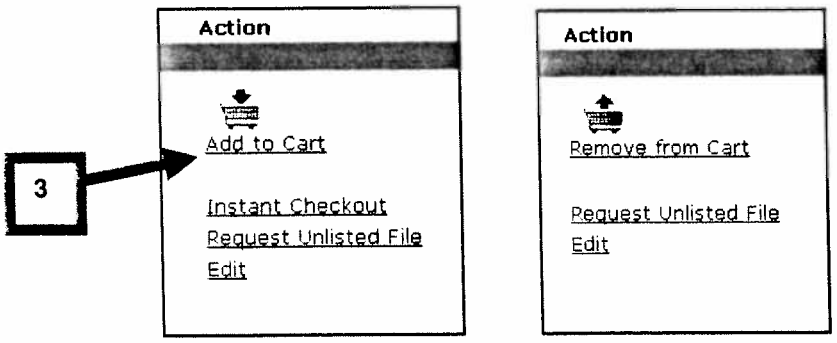
Once the results have returned, you have various options in order to complete the order process.

The options available will vary according to the user privileges you have been granted by the company administrator.

- **Add to Cart**: Add the selected item directly to your cart and continue searching and adding items to your cart
- **Instant Checkout**: Allows you to select one item and go directly to checkout screen
- **Request Unlisted File**: Select specific file from a box that is not individually listed with descriptions
- **Edit**: Allows you to edit any of the fields that were input during the data entry process

3. Click Add to Cart

Note: The Add to Cart link turns red and changes to Remove from cart after the item has been added.

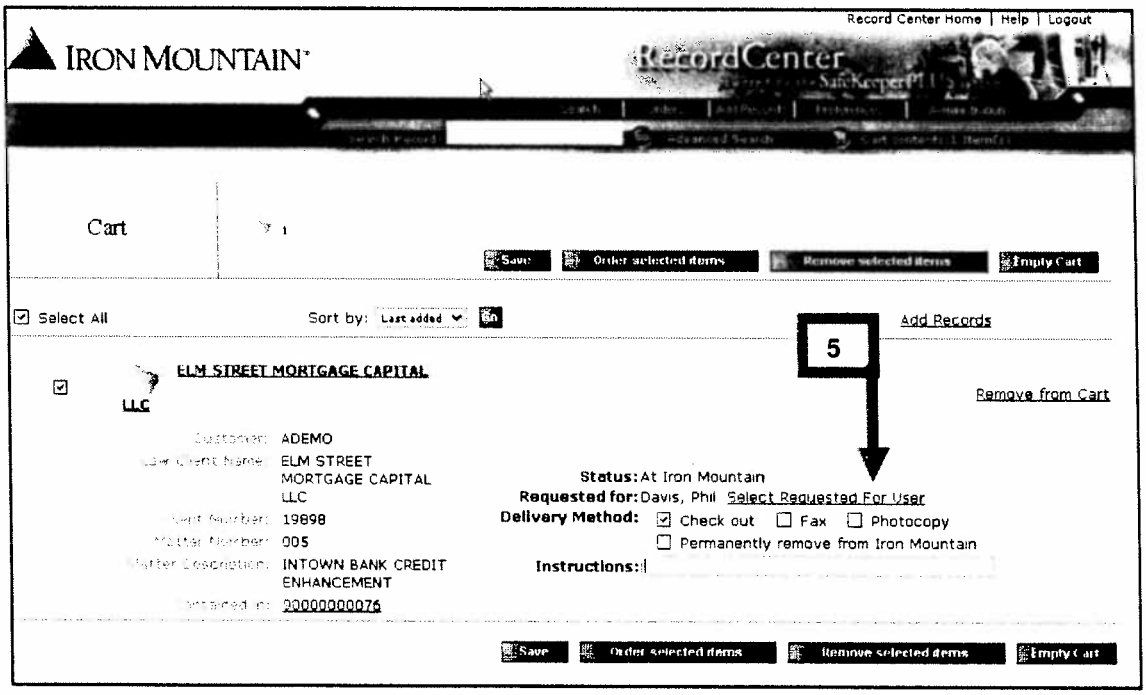


The system adds items to the Cart.

4. From the top of page, click the Cart contents link or shopping cart icon:

The system displays Cart options screen.

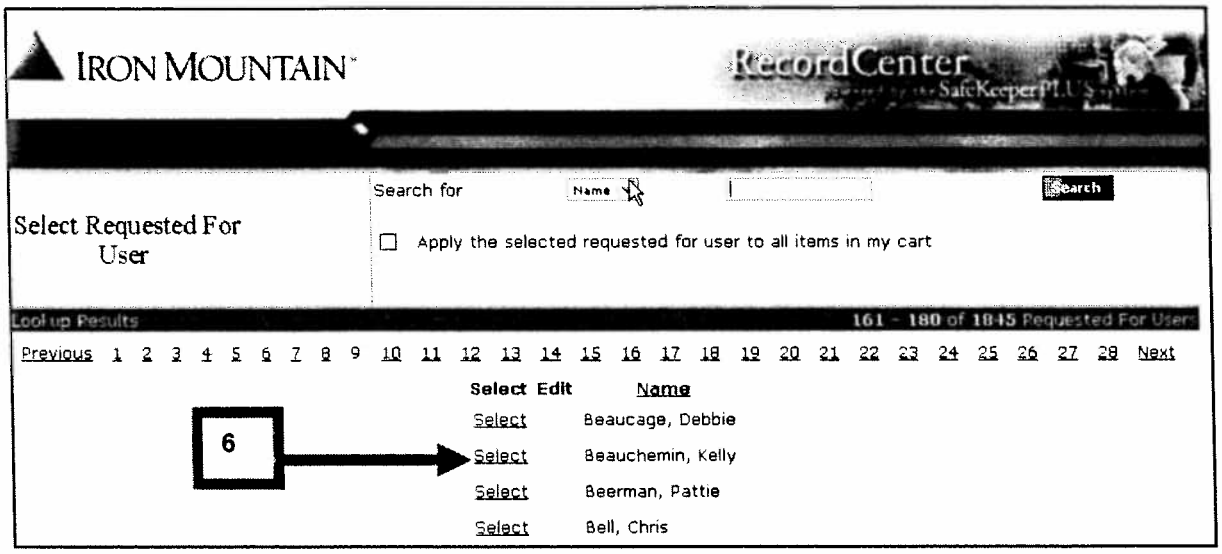
5. Click Select Requested For User:



Note: You have the option to change any preferences selected including who you would like the box or file delivered to.

The system displays the Selected Requested For User screen.

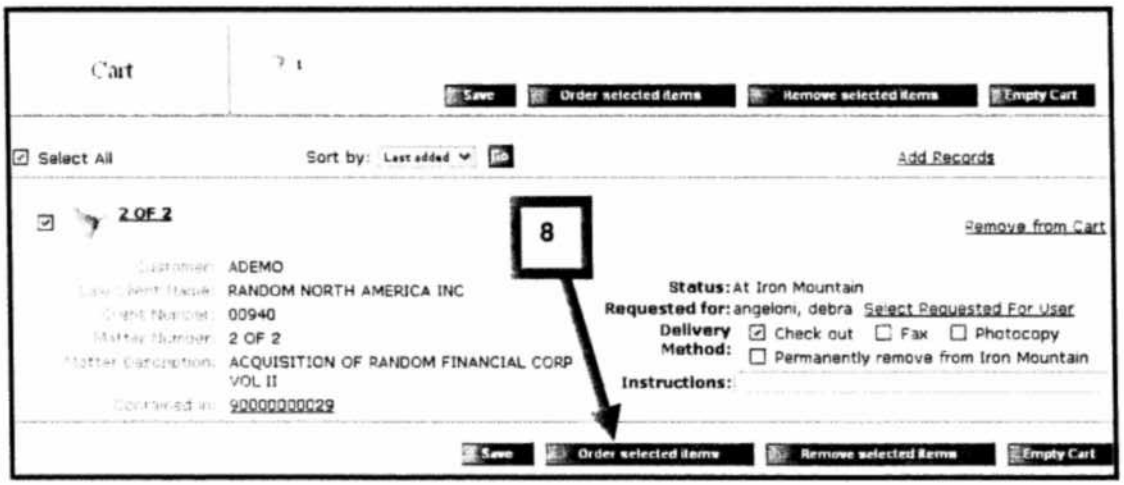
6. Click Select next to the name of the desired recipient.



7. From the Cart Options screen, review details, make any revisions, and select one of the following options:

- Save (save the order and complete the process at another time)
- Order selected items
- Remove selected items from cart
- Empty Cart

8. Click Order Selected Items:



The system displays the Checkout screen.

9. Verify/update the following and click Proceed with Checkout:

- Priority option
- Order option
- Instructions
- Email confirmation (provide at least one; you may add up to three)

Checkout

Proceed with Checkout | Go to Cart

Delivery to
Address: 604 General Washington Avenue
Norristown, Pennsylvania 19403
United States

Phone: (610) 831-2991
Change Address

Priority
Next Day by Wednesday, 09/20/2006 at 05:00:00 PM (EDT)
Half Day by Wednesday, 09/20/2006 at 12:00:00 PM (EDT)
Rush by Tuesday, 09/19/2006 at 02:11:08 PM (EDT)
Scheduled

Order Options
Carrier: Iron Mountain
Customer will pickup
Instructions:
Email confirmation to: phyllis.davis@ironmountain.com Remove
Add email address
Attention To

Details
Retrieval for : ADEMO [IMRM DEMO ACCOUNT (11)]
Bill to Cost Center Code: MASTER
P.O. Number:
Chargeback:

Record: Box
Key Identifier: OO
Customer: ADEMO
Cost Center Code: LAW
Record Code: LIT01
Major Description: BOBS VM
Minor Description: NNNNNNN

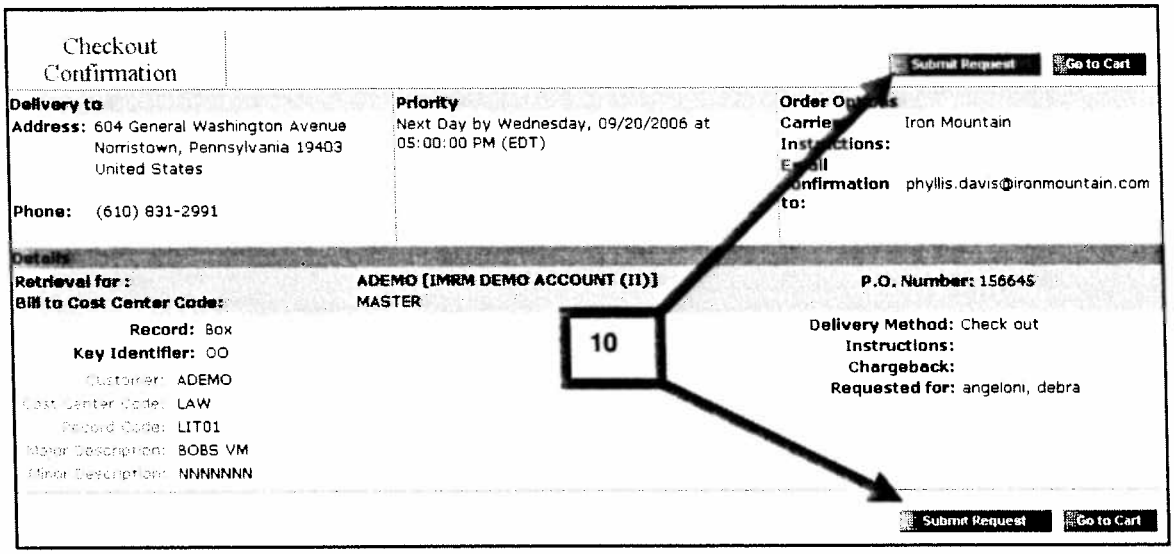
Delivery Method: Check out
Instructions:
Chargeback:
Requested for: angeloni, debra
Select Requested For User

9

Proceed with Checkout | Go to Cart

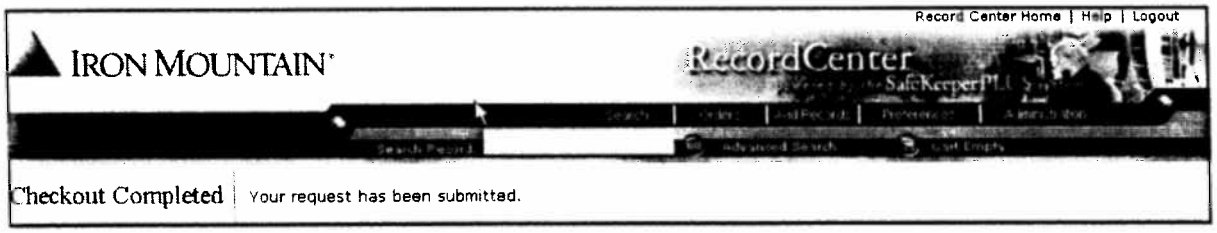
The system displays the Checkout Confirmation screen.

10. Click Submit Request:



The system displays Checkout Completed screen.

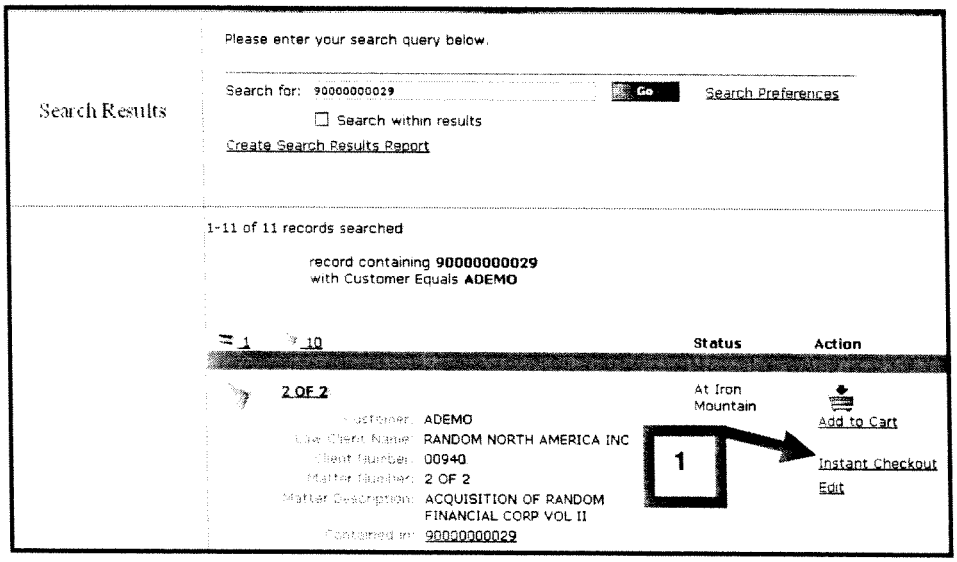
Note: You will receive an email confirmation.



Instant Checkout

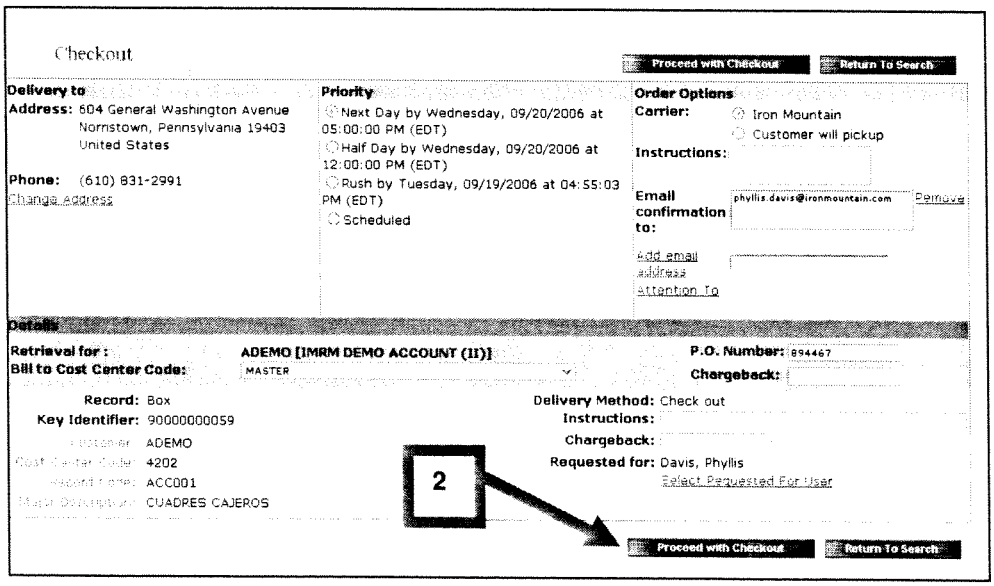
If you are not ordering multiple items (ordering only one item box/file), the Instant Checkout feature allows you to check out immediately, bypassing the need to review the box/file in your cart before checking out.

1. Click Instant Checkout:



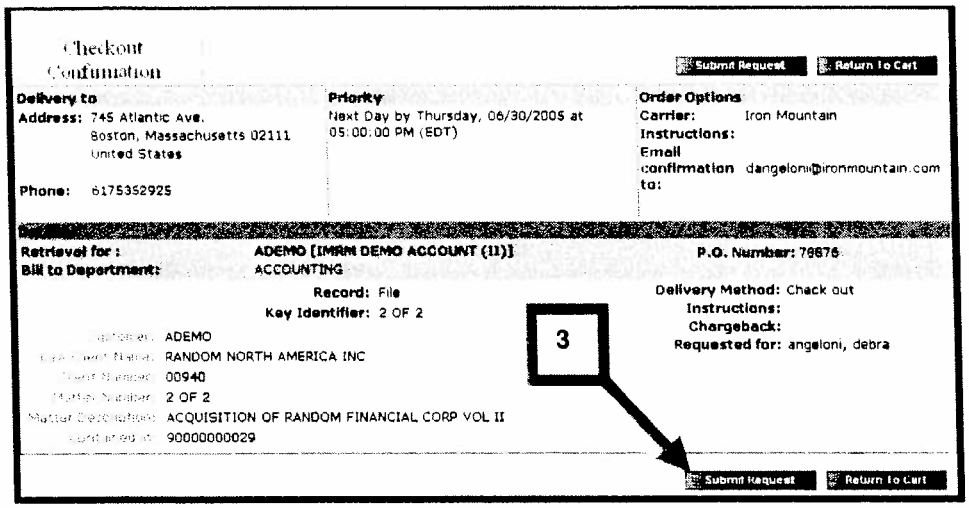
The system displays the Checkout screen.

2. Click Proceed with Checkout:



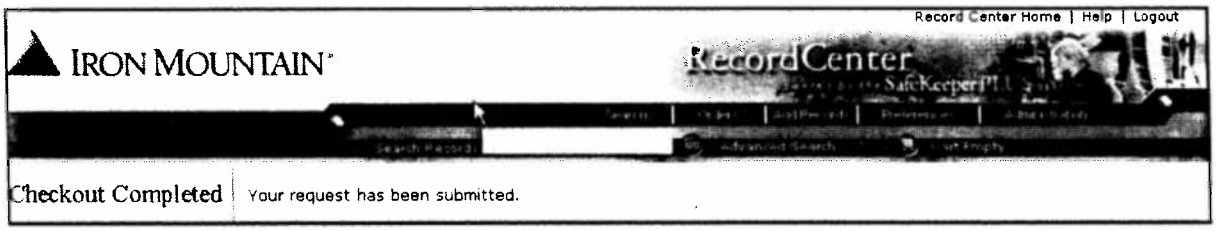
The system displays Checkout Confirmation screen.

3. Click Submit Request:



The system displays Checkout Completed screen.

Note: You will receive an email confirmation.



Requesting an Unlisted File

Unlisted files are stored files that have not been individually listed. This means that Iron Mountain's inventory does not include file level descriptions of what is inside your box.

To request an unlisted file, you first create a record for the file.

When you create a record for an unlisted boxed file, the data format that you type your information in to depends on the department for the box the file resides in. For example, if the box is from your legal department, then the new file record is in the Law File data format. If no department is specified on the box record, then the new file record is in the Standard File data format.

When you create a record for an unlisted Open Shelf file, you select an existing file group or the new file record.

Boxed Files

To request an unlisted boxed file:

1. On a Search Results or Box Details screen, click Request Unlisted File (next to a box record).

2. In the Request Unlisted File window, complete all fields:

File Description 1	
File Description 2	

(This example is for the Standard File data format.)

3. Do one of the following:

    - To add the file to your Cart, click Add to Cart
    - To order the file now, click Instant Checkout
    - To cancel your request, click Cancel

Note: The value entered in the top field of the Request Unlisted File window becomes the key identifier of the new record.

Open Shelf Files

To request an unlisted Open Shelf file:

1. Using Quick Order Entry, search for Open Shelf files

2. In your Quick Order Entry results, click Create unlisted files

3. In the Request Unlisted File window, complete the file description fields

4. Select the file group(s) in which the file is located:

☐ **Select all File Groups**
☐ GROUP ONE
☐ GROUP TWO

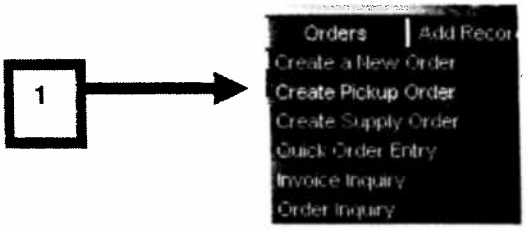
5. Click Save and Return.

Note: The fields that appear in the "Request Unlisted File" window depend on the data format of the Find In field. For example, if you searched for a patient name in Quick Order Entry, the description fields are from the Medical File data format. If the Find In field is File Description 1, the Standard File data format is used.

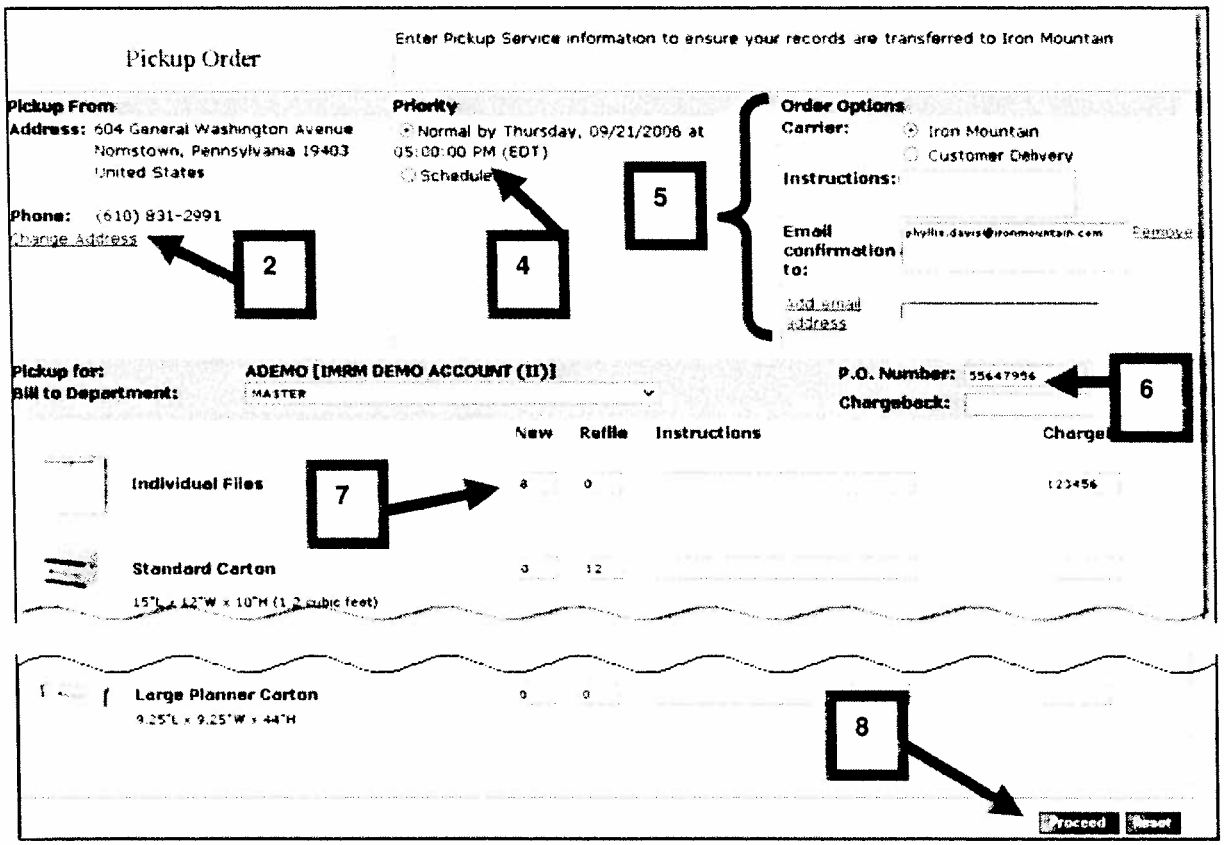
Creating a Pickup Order

You can create pickup orders for items to be transported to an Iron Mountain storage facility. On your pickup orders, you can select the pickup address, service priority, billing and line-item instructions, and vault service. To create a pickup order, follow these steps:

1. Click Orders and select Create Pickup Order.



The system displays the Pickup From screen.

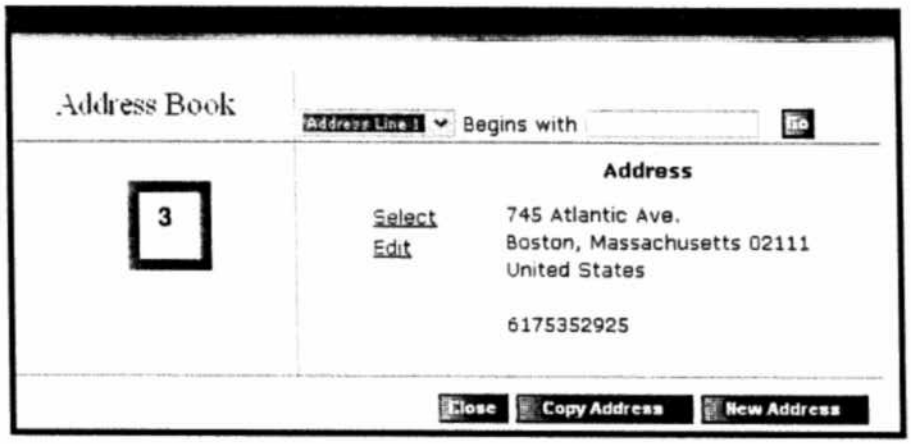


2. If necessary, click Change Address to select another Pickup From address:

The system displays Address Book screen.

3. Select/type revisions needed from the Address Book screen:

- Click Address Line and select from dropdown list
- To update/revise address information, click Edit, make changes, click Use this address
- Click New Address to provide new address info or click Select, and click Close



4. Select a Normal service Priority:

Note: To schedule a later pickup, select a Scheduled service Priority. Type a date in MM/DD/YYYY format or click the calendar icon and select a date.

5. Select/type the following from the Order Options screen:

- Select a Carrier (i.e., Iron Mountain or Customer Delivery)
- Enter up to 120 characters of order-level Instructions
- Type Email confirmation address. You may provide up to three email addresses. To add an address, type the email address in lower box and click Add email address.
- To remove an address, highlight it and click Remove.

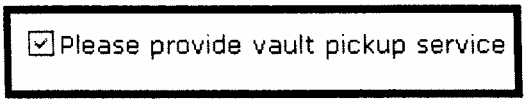
6. Select/type the following billing information:

- Select Bill to Division or Bill to Department from the drop down list.
- Enter a P.O. Number (up to 17 characters) and a Chargeback code (up to 20 characters)

Note: The option to bill to other departments depends on how your account is setup with Iron Mountain. Not all customers will have this option.

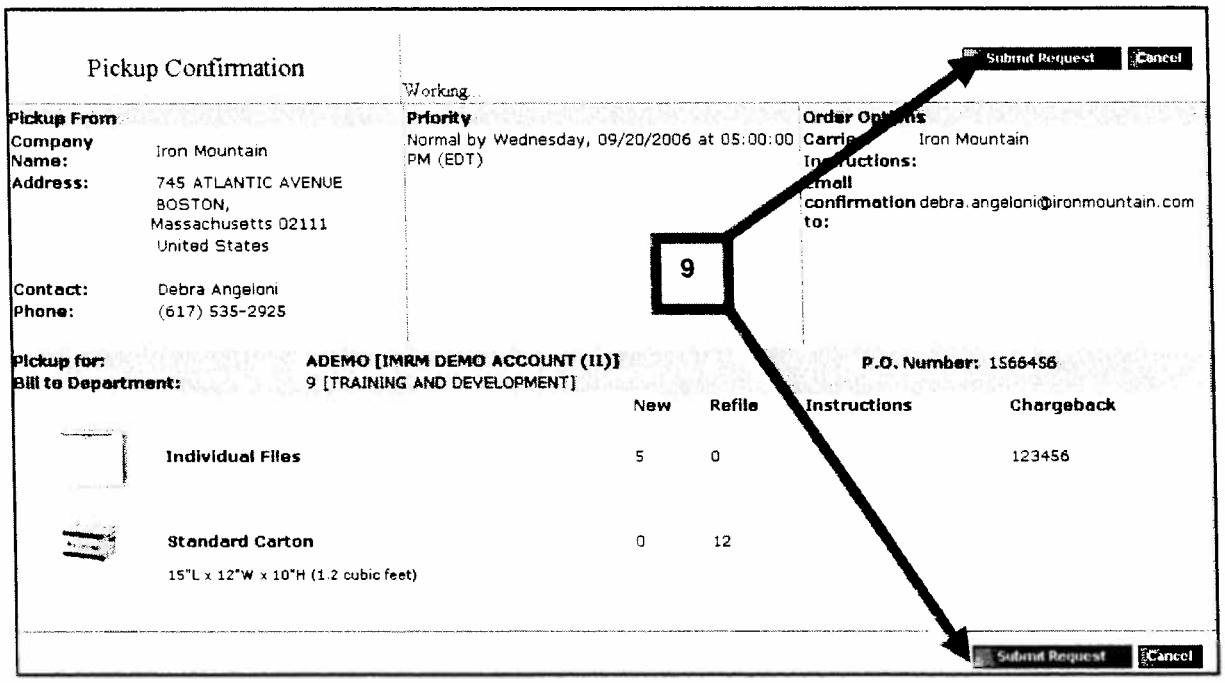
7. Type the number of New and Refile items in the files and/or boxes (cartons) and applicable instructions (up to 120 characters). Enter the Chargeback code, if applicable.

8. To request vault service, select Please provide vault pickup service and click Proceed.

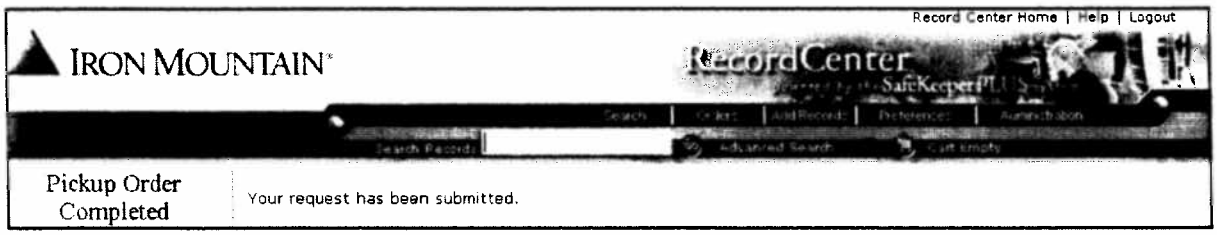


The system displays the Pickup Confirmation screen.

9. Click Submit Request:



The system displays the Pickup Order Completed screen.



You can select the following types of file and boxes (cartons) to be picked up:

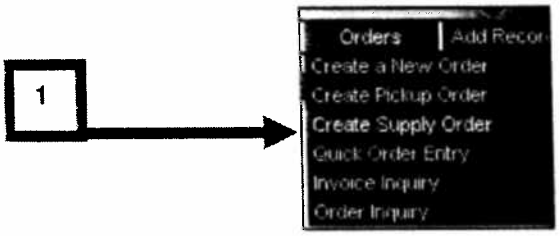
File and Box Types

File or Carton Type	Model #	Dimensions (Capacity)	Uses
Individual Files	NA	Vary	Vary
Standard Carton	2000	15" L x 12" W x 10" H (1.2 ft3)	For letter (8.5" x 11") or legal (8.5" x 14") files.
Check Carton	844	24" L x 9" W x 4.5" H	For checks, deposit slips, time cards, cassette tapes, videotapes, and similarly sized documents.
Letter Transfer Carton	450	24" L x 12" W x 10" H (2.4 ft3)	For the contents of a file drawer, twice the capacity of the Standard Letter carton.
Legal Transfer Carton	550	24" L x 15" W x 10" H (3.6 ft3)	For the contents of a file drawer.
X-Ray Carton	200	15" L x 6.25" W x 10" H (1.8 ft3)	For x-rays, ledger books, and similarly sized documents.
Small Planner Carton	630	4" L x 4" W x 42" H	For rolled maps, blueprints, plans, and drawings.
Large Planner Carton	632	9.25" L x 9.25" W x 44" H	For the contents of four (4) Small Planner cartons.

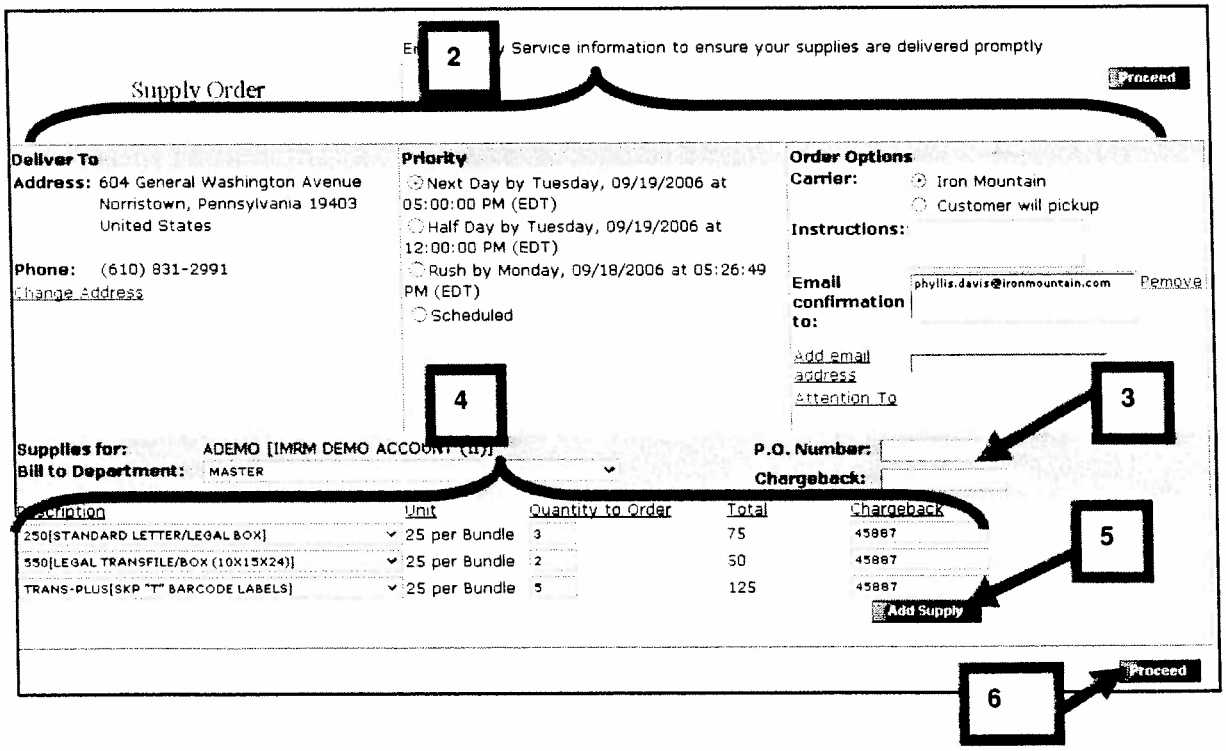
Creating a Supply Order

You can create orders for empty boxes, transmittal sheets, bar code labels, and other storage supplies from Iron Mountain. Depending on your security access, you can create orders and bill supplies to different divisions and departments. For supply prices and a detailed description of supplies, please contact your Iron Mountain Account Manager or Iron Mountain directly. To create a supply order, follow these steps:

1. Click Orders and select Create Supply Order:



The system displays the Supply Order screen.



2. Verify the Deliver to, Priority and Service options (same as with Ordering options)

3. Complete the following billing information:

    - Select Bill to Division or Bill to Department from the drop down list

    - Enter a P.O. Number (17 characters max) and a Chargeback code (20 characters max)

4. Select your supplies from the drop down list under Description.

    - From the Quantity to Order box, type the number of units (bundles). Supplies can be ordered in whole units (bundles) only.

    - The total number (units times the quantity to order) of supply items is automatically calculated.

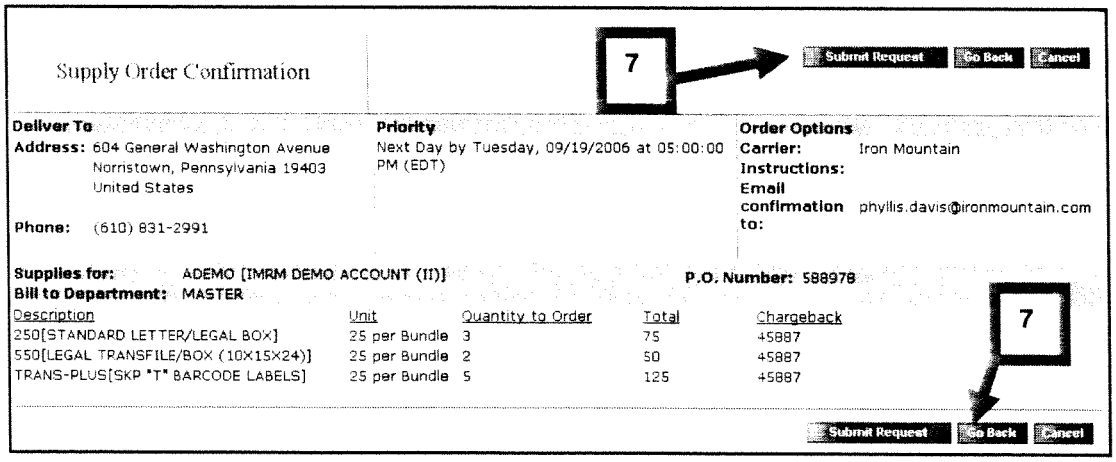
    - Type a Chargeback code in the Chargeback box (optional for supply items)

5. Click Add Supply. You can change the total by entering a new quantity to order.

6. Click Proceed.

The Supply Order Confirmation screen is displayed.

7. Click Submit Request or click Go Back to change your order:



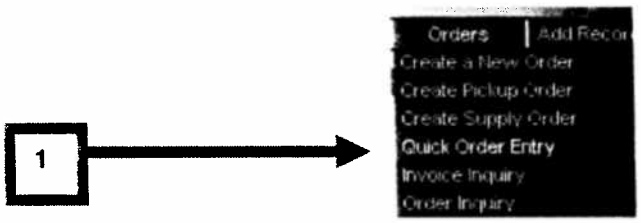
Creating a Quick Order Entry

Quick Order Entry is a rapid order entry command. It is best used when you know which file(s) you would like to order.

- You must first set and or edit your Quick Order Entry Preferences. You can find and add boxed files and Open Shelf files, including unlisted Open Shelf files.
- Files with Find In field values that exactly match your search word(s) are automatically added to your Cart (up to the selected maximum) when you search for boxed files. In addition, files with Find In field values that match the beginning of or your full search word(s) are added to your Cart when you search for Open Shelf files.
- You can also create unlisted Open Shelf files from the applicable file groups and add them to your Cart.
- Quick Order Entry searches are limited to a single field (called the Find In field) in records. To select the Find In field, change your Quick Order Entry preferences.

You must first set/edit your Quick Order Entry Preferences, see steps below:

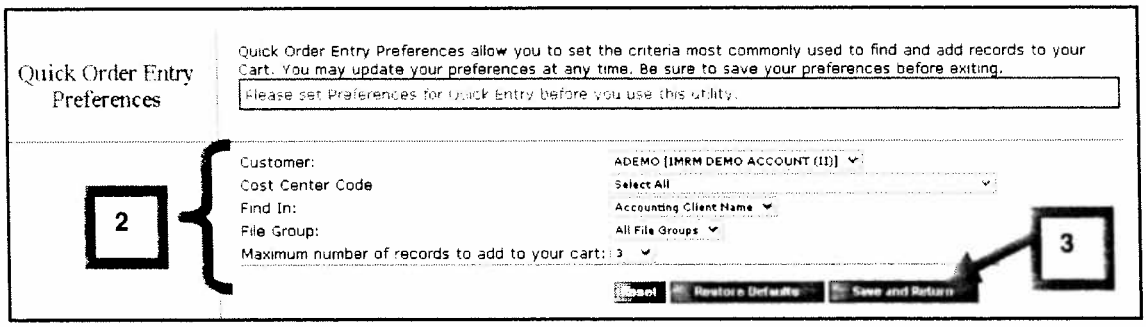
1. Click Orders and select Quick Order Entry.



The system displays Quick Order Entry Preferences screen.

2. Set your Preferences.

Note: As your Quick Order Entry search criteria changes, you must revise your preferences.

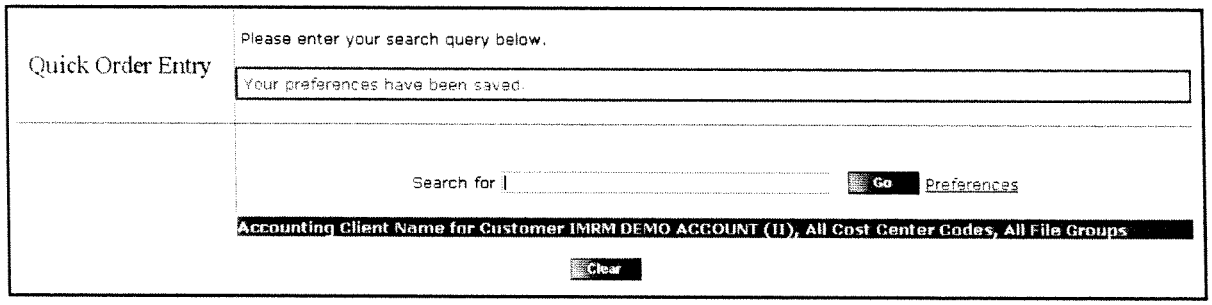


- Select the Customer from the drop down list
- Select the Cost Center from the drop down list
- Select a search criteria from the Find In drop down menu
- Select a File Group from which to search from the drop down menu
- Select a number from the drop down list for Maximum number of records to add to your cart

3. Click Save and Return

Note: you can modify your Quick Order Preferences at any time.

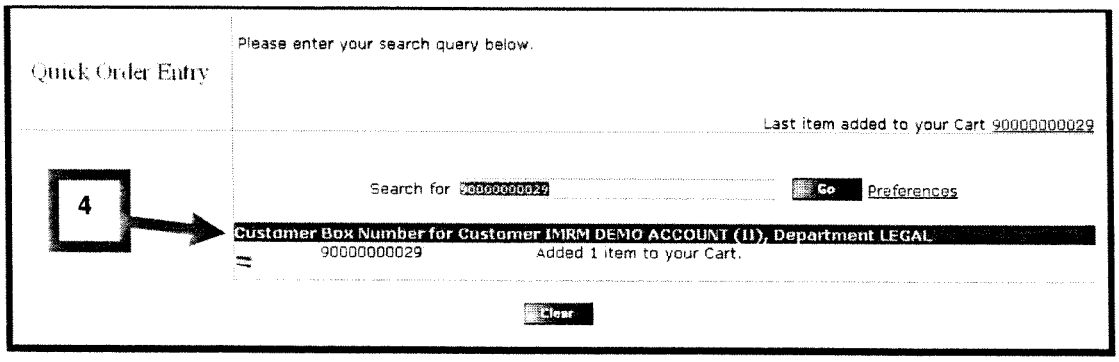
The system returns to the Quick Order Entry screen.



Enter the Search for values in the screen based upon your Preferences and click Go.

Note: If you are searching for boxed files, type the exact value you want to find. If you are searching for Open Shelf files, type the beginning of a Find In field value (e.g., box number 90000000029).

4. The system displays a confirmation that the item was added to your cart.



Troubleshooting:

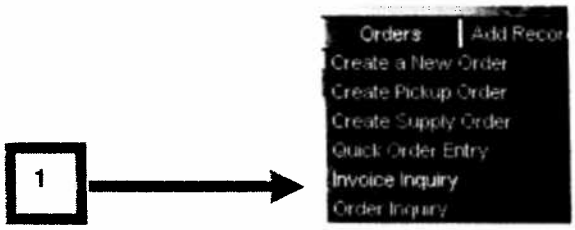
- If you searched for Open Shelf files, and no records are found, the data does not match the format for this File Group or the data does not match any File Group.
- If you searched for Open Shelf files, you can click Create unlisted files to add unlisted files to your Cart.
- If more than the maximum number of records that can be added to your Cart by one quick order entry are found, click More to view the records.
- If records are added to your cart, do one of the following:
- To do another quick order entry, search for a new Find In field value, or change your preferences
- To view the last item added to your Cart, click the key identifier of the record
- To clear your results, click Clear

Note: Your quick order entry results are listed until you clear them or log off from the Record Center. Clearing your results **does not** remove records from your Cart.

Searching for and Viewing an Invoice

You can search for Iron Mountain invoices by date range, invoice number, or order number. Invoices can be viewed by month, customer, division, and department. To search for and view an invoice, follow these steps:

1. Click Orders and select Invoice Inquiry:



The system displays the Invoice Inquiry screen.

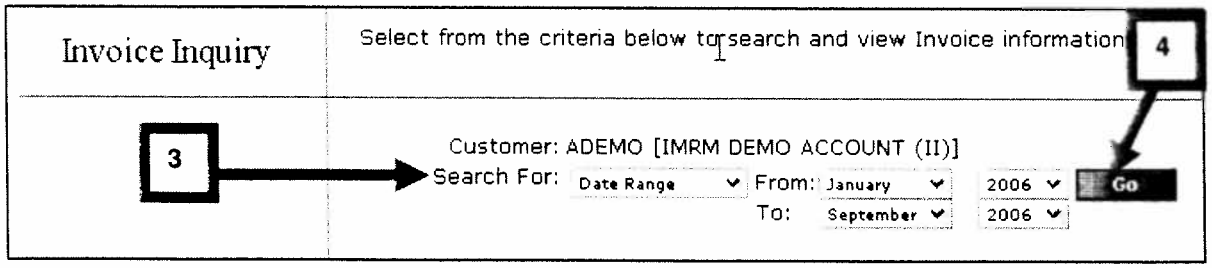
2. Select the Customer and click Go:

3. Select a Search For option (i.e., Date Range, Invoice Number, or Order Number) from the drop down list.

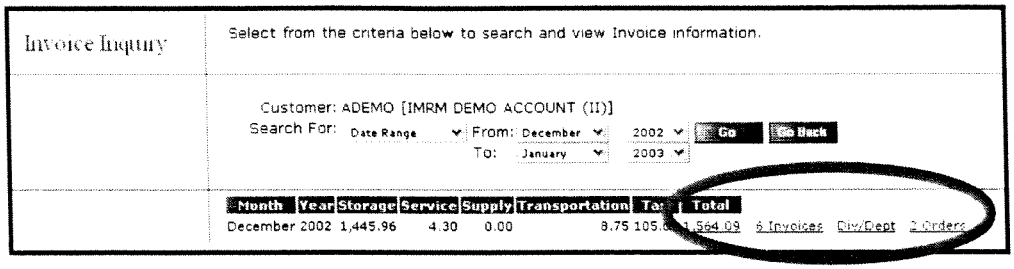
- If you search by date range, select a month in the From and To drop down lists to view more details.
- To view all the transactions for a month, click its Total:

4. Click Go:

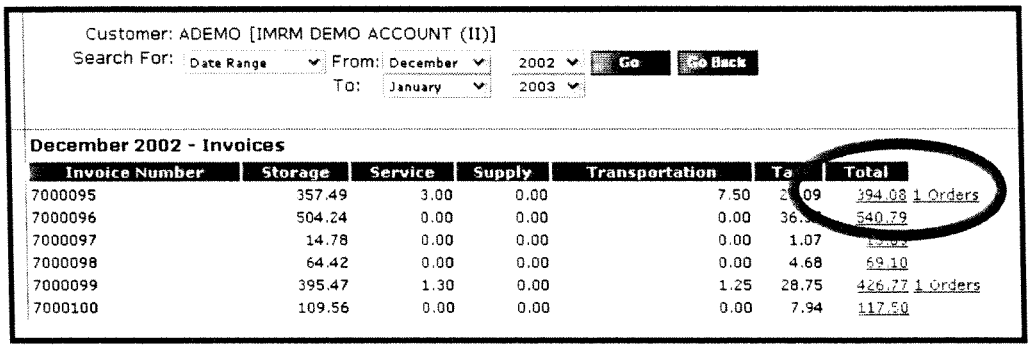
Note: The Customer name will default to your company/account name.



The system displays the Invoices requested.



- To view all the invoices for a month, click the total number of invoices.
- Click an invoice total to view its transactions.
- To view the division and department totals for a month, click Div/Dept:



- Click Go Back to go back to main invoice page.

Note: Invoice charges are determined by the rate schedules and units of measure for the listed transactions. A bill code relates each transaction to the applicable rate.

Invoice Charges

Charge	Unit of Measure	Description
Storage	Cubic feet (ft3)	Storing items at Iron Mountain
Service	Number of transactions	Services such as handling boxes and files, entering and changing records, and database searches
Supply	Number of supplies	Supplies such as empty boxes, file folders, handbooks, and other materials from Iron Mountain
Transportation	Number of shipments or parts of a shipment	Picking up, delivering, and transmitting items and copies to and from storage
Tax	USD or applicable currency	Federal, state, local, and other applicable taxes

Searching for and Viewing an Order

An order is processed when Iron Mountain generates a packing slip for it. This normally occurs when the order is confirmed.

- Retrieval and permanent withdrawal orders: confirmation occurs when the stored items are removed from their shelves and scanned and ready for shipping.
- Pickup orders: confirmation occurs when Iron Mountain receives the order from the customer.

You can find orders that are submitted to Iron Mountain by their order number, request date, order type, or request by user. Depending on their order type and order status, you can view, edit, and cancel orders.

Note: Iron Mountain deletes inactive orders on a weekly basis. An inactive order is a processed order that lists no transactions for six months.

To display an order, follow these steps:

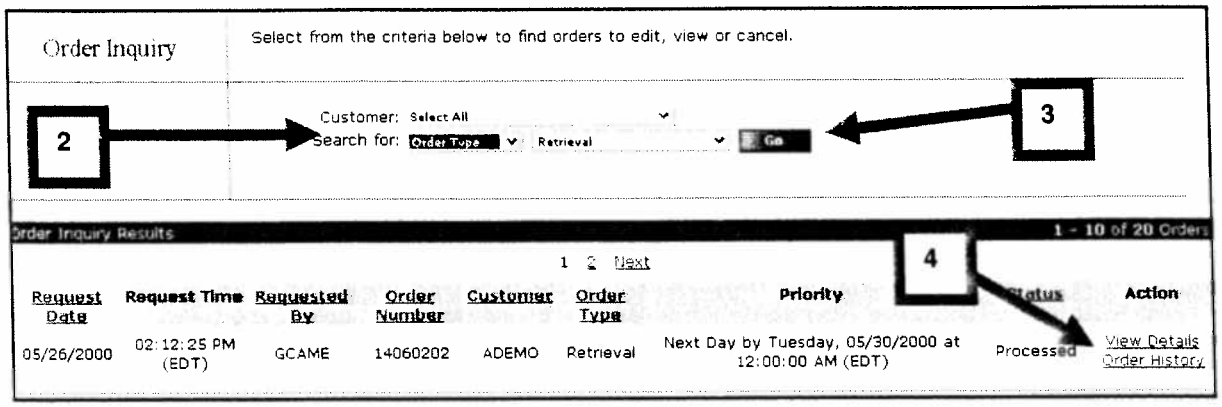
1. Click Orders and select Order Inquiry:

The system displays the Order Inquiry screen.

2. Select from following:

- Select a Customer from the drop down list
- Select one of the following Search for criteria from the drop down list:
- To search by Order Number, type an order number
- To search by Request Date, type a date (click and select a date)
- To search by Order Type, select All and a month and year, or select an order type.
- To search by a Requested By user, type all or part of the user's first name, last name, or the Iron Mountain Connect username.

Note: When searching for orders by "Requested By" user, only orders that are submitted using the Record Center are displayed (not SafeKeeperPLUS or other means).



3. Click Go.

4. Click View Details Order History for additional information.

The system lists orders by their Order Number.

5. Click a page number link to browse the results:

Note: If there is more than one result, page number links will appear at bottom of screen.

Previous 1 2 3 4 5 6 7 8 9 10 11 Next

Additional Order Inquiry Functionality:

If the order status is...	Then click...
Submitted for processing	View Details to display an order Edit Order to edit an order Cancel Order to cancel an order
Processed	Order History to view the transaction history of an order
Any other status	View Details to display an order

Working with Other Types

Order types specify the nature of a request for service to Iron Mountain and the actions you can perform on orders using the Record Center.

Order Type	Description	Actions*
Retrieval	Retrieve items from storage at Iron Mountain and deliver them to a customer.	Submit Request, View Details, Order History, Edit Order, Cancel Order
Permanent Withdrawal	Permanently remove items from storage at Iron Mountain and return them to a customer.	Submit Request, View Details, Order History, Edit Order, Cancel Order
Pickup	Pick up items from a customer and deliver them to an Iron Mountain storage facility.	Submit Request, View Details, Order History, Edit Order, Cancel Order
Supply	Purchase storage supplies, such as boxes and transmittal sheets, from Iron Mountain.	Submit Request, View Details, Order History, Cancel Order
Destruction	Destroy specified items that are stored at Iron Mountain.	View Details, Order History
Image Request	Retrieve images from storage at Iron Mountain and deliver them to a customer.	View Details, Order History
Destruction	Destroy specified items that are stored at Iron Mountain.	View Details, Order History
Research	Find and verify, but do not retrieve, stored items.	View Details, Order History

* The Edit Order and Cancel Order actions can be performed only on orders that have the Submitted for processing order status. In addition, you cannot cancel an order that is being edited by another user.

Order Status

Order status indicates the current disposition of requests for records or supplies. See the following:

Order Status	Description
Being updated	Order is currently being updated by a user.
Awaiting customer authorization	Destruction order is on hold awaiting authorization by the customer.
Submitted for processing	Order was posted and can be released for processing.
Being processed	Order has been fully or partially released for processing by Iron Mountain.
Processed	Order was processed by Iron Mountain.
Cancelled	Order was cancelled and will not be processed.
On hold	Order was placed on hold, and is not being processed, at the customer's request or for credit reasons.

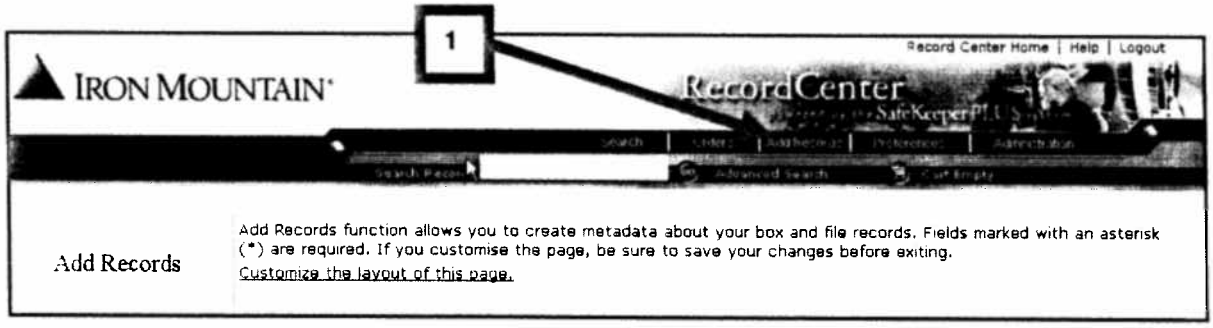
Module Four: Adding Records in the Record Center

Adding Records

You have the option of adding new inventory (boxes and files) to the Record Center through the Iron Mountain Connect™ system.

- When you add data into the system through Add Records, only the online data exists in our system at that time. It is held in a virtual "holding area." You must then create a pickup order to have an Iron Mountain courier come and pick up the boxes.
- Once the boxes are scanned into Iron Mountain (approximately 24 - 48 hours), the information is matched in the system and you may search and place orders for that inventory.
- Only authorized users who have been provided with Inventory Maintenance access will be able to see this function on their screen. This lets them add the information from their desktop.

1. From the top menu bar, click on Add Records:



The system displays the Add Records screen.

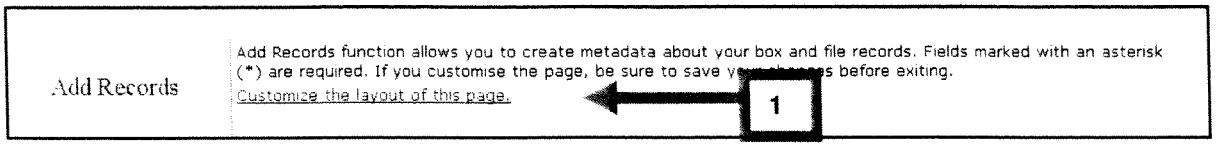
Note: The first time you access this page, you may want to choose the Customize the layout of this page hyperlink. Customize the page will allow you change the page layout and enable/disable functions that will be helpful when adding new data into the system.

The customer administrator will ensure that all required fields remain enabled by setting them as a custom field in the initial set-up.

This will prevent any of the users given access to this section the guidance on the correct fields that need to be completed when sending records and data to Iron Mountain.

Customize the Layout for Add Records

1. Click Customize the layout of this page.

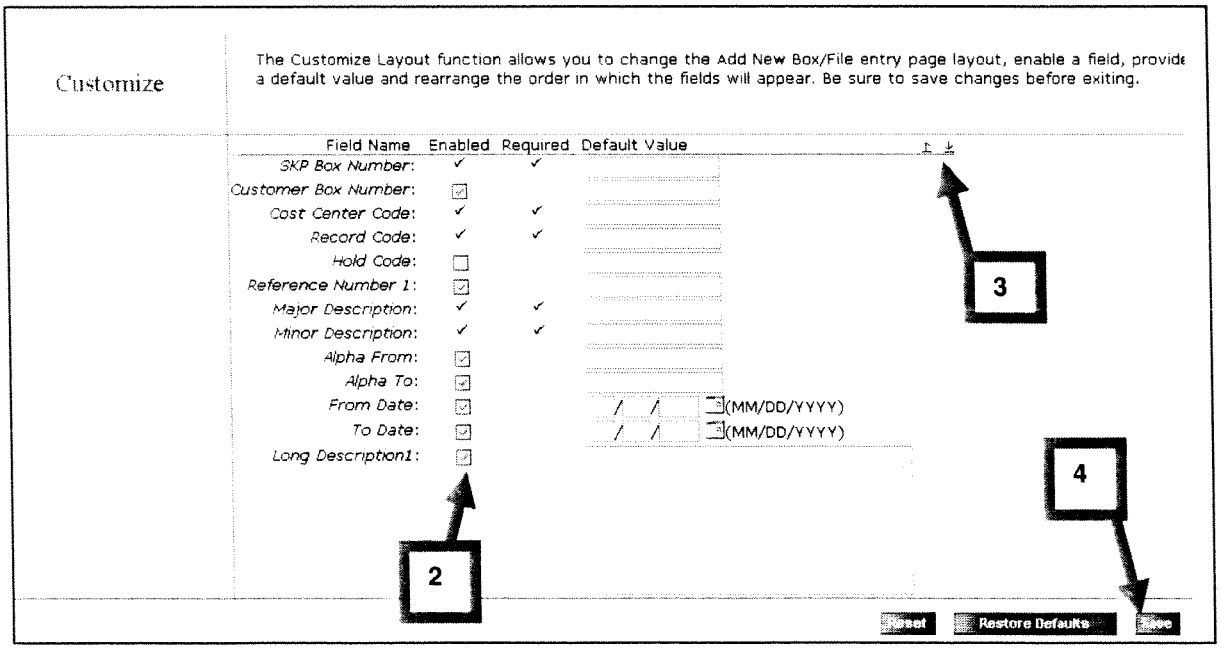


The system displays the Customize screen.

2. Select or deselect (checkbox) under Enabled column and provide a Default Value (if applicable)

3. Use the up and down arrows to rearrange the order of Enabled Functions

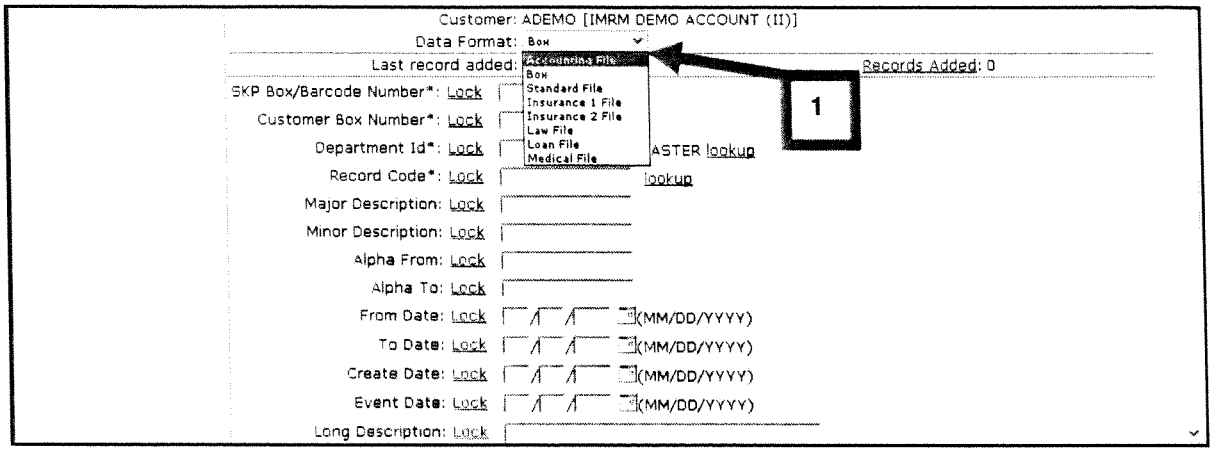
4. Click Save to save all customized changes made



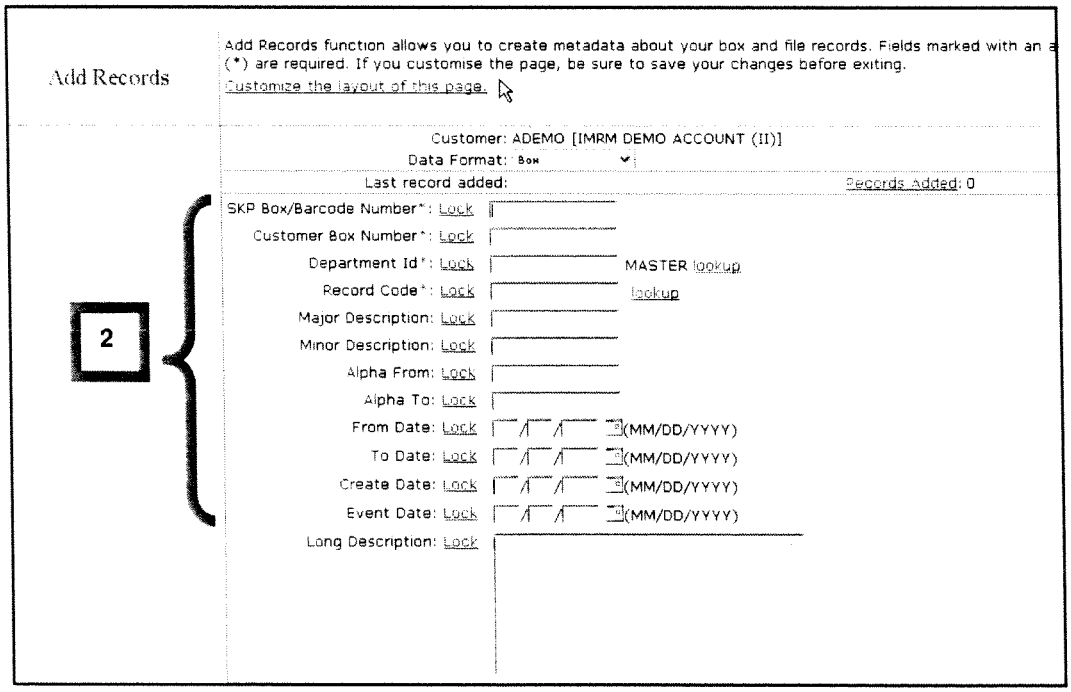
The system displays the Add New Box/File screen.

Process to Add Files/Boxes

1. Select a Data Format from the drop down list.



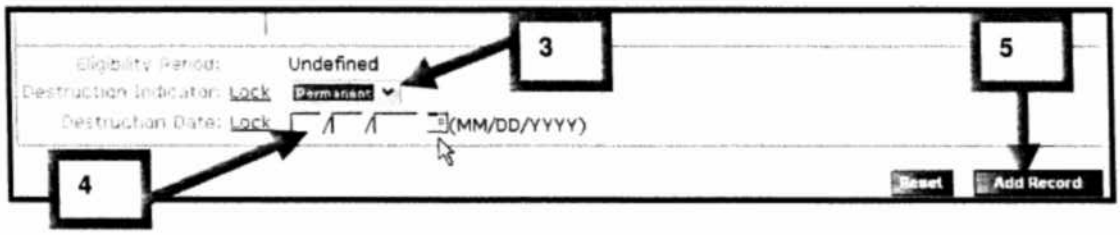
2. Once data format is selected, fill in all applicable fields. All fields with a Red Asterisk (*) are required fields:



3. Select Destruction Indicator status from the drop down list

4. Enter a Destruction Date (or click calendar icon to select date)

5. Click Add Record.

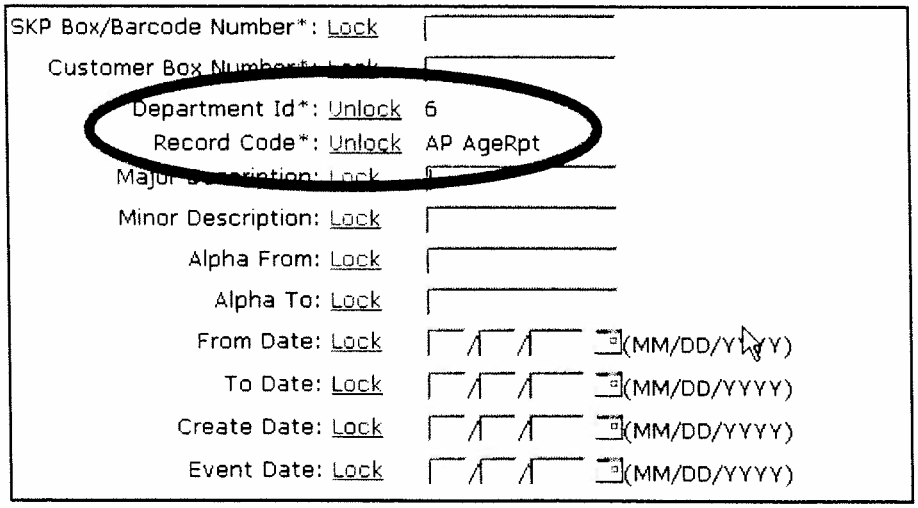


The system displays number of the Records Added confirmation screen.

Locking Fields

For quicker data entry, the system provides a feature that allows you to LOCK or UNLOCK each field as you enter your information.

The benefit is that you can "LOCK" a specific field to keep the same information as you enter multiple records. For example, you may want to lock your Department ID field because all of the records you are entering relate to the same department.

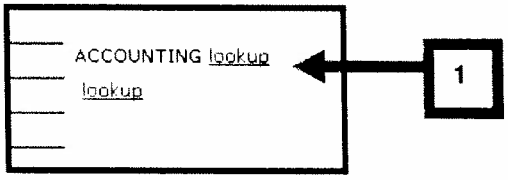


Code Lookup

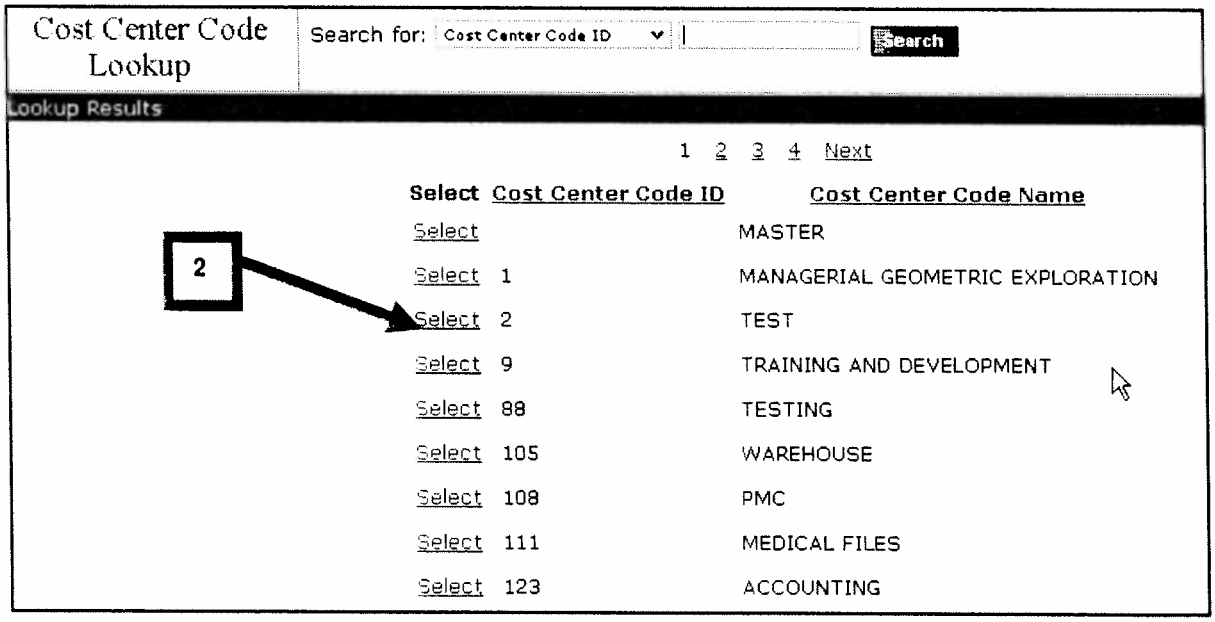
When adding a new box/file to the system, you have the ability to lookup any Department IDs and Record Codes associated with the account. The following example illustrates Department ID/Cost Center.

Note: In order for this functionality to work properly, you need to be set up to validate departments within the SafeKeeperPLUS® system.

1. Click lookup:



The system displays the Department Lookup screen.



2. Click the Select hyperlink next to the desired Department ID to enter the value in the field.

Completing the Process

- Once you have entered any files or boxes to the Record Center through the Iron Mountain Connect system, you must complete any paperwork needed, such as the Transmittal Form, to prepare to physically send your information to Iron Mountain.

- Once you have entered the information, you would proceed to the Order Function, and Create a Pick up Order.

- Inventory that has been entered via Add Records will be available after Iron Mountain scans the physical record into our SafeKeeperPLUS system and matches it to the paper work or meta data submitted.

- It takes approximately 24 - 48 hours before the records are searchable using the basic or advanced search functions within the Iron Mountain Connect system.

- However, if you need to locate the information, data in the Quick Order Entry function is available immediately for the entered record.

Viewing Data Formats

The following are data formats for each type of file.

Note: Date formats are based on the option selected in the My Profile area.

Accounting Files

Field Name	Maximum Characters	Description
SKP Box Number	11	Bar code number, provided by Iron Mountain, that identifies a box
Customer Box Number	11	Customer-defined alphanumeric identifier of the box that contains this file
Division	12	Alphanumeric identifier of the division or similar organizational unit to which the file belongs
Department	12	Alphanumeric identifier of the department or other subdivisional unit to which the file belongs
Record Code	10	Customer-defined alphanumeric code that defines a record type within a division or department and indicates how the destruction date of a file is calculated
Client Name	26	Name of the client associated with the file
Client Number	24	Customer-specified number for the client associated with the file
From Date	MM/DD/YYYY	Beginning of a customer-specified date span
To Date	MM/DD/YYYY	End of a customer-defined date span
Destruction Date	MM/DD/YYYY	Date on which the file is to be or was destroyed by Iron Mountain, based on customer instructions or calculated from the retention schedule of its record code
Alpha From	10	Beginning of a customer-defined alphanumeric sequence by which the file is classified

Boxes

Field Name	Maximum Characters	Description
SKP Box Number	11	Bar code number, provided by Iron Mountain, that identifies a box
Customer Box Number	11	Customer-defined alphanumeric identifier for the box
Division ID	12	Alphanumeric identifier of the division or similar organizational unit to which the box belongs
Department ID	12	Alphanumeric identifier of the department or other subdivisional unit to which the box belongs
Record Code	10	Customer-defined alphanumeric code that defines a record type within a division or department and indicates how the destruction date of a file is calculated
Hold Code	3	Customer-defined code that overrides the retention schedule for a box, postponing its destruction until further review
Reference Number 1	25	Additional alphanumeric identifier, typically used for legacy storage systems
Reference Number 2	25	Additional alphanumeric identifier, typically used for legacy storage systems
Major Description	30	Primary description of the box
Minor Description	30	Secondary description of the box
Alpha From	10	Beginning of a customer-defined alphanumeric sequence by which the box is classified
Alpha To	10	End of a customer-defined alphanumeric sequence by which the box is classified
From Date	MM/DD/YYYY	Beginning of a customer-specified date span
To Date	MM/DD/YYYY	End of a customer-specified date span
Create Date	MM/DD/YYYY	Date on which the box record was added to the Record Center
Event Date	MM/DD/YYYY	Date of any customer-specified event
Destruction Indicator	Select option	Reason that the destruction of the box has been put on hold.

Field Name	Maximum Characters	Description
Destruction Date	MM/DD/YYYY	Date on which the box is to be or was destroyed by Iron Mountain, based on customer instructions or calculated from the retention schedule of its record code
Long Description	2,500	Extended description of the contents of a box

Standard Files

Field Name	Maximum Characters	Description
SKP Box Number	11	Bar code number, provided by Iron Mountain, that identifies a box
Customer Box Number	11	Customer-defined alphanumeric identifier for the box
Division ID	12	Alphanumeric identifier of the division or similar organizational unit to which the box belongs
Department ID	12	Alphanumeric identifier of the department or other subdivisional unit to which the box belongs
Record Code	10	Customer-defined alphanumeric code that defines a record type within a division or department and indicates how the destruction date of a file is calculated
From Date	MM/DD/YYYY	Beginning of a customer-defined date span
To Date	MM/DD/YYYY	End of a customer-defined date span
File Description 1	30	Primary description of the file and its contents
File Description 2	30	Secondary description of a file and its contents
File Description 3	30	Tertiary description of a file and its contents
File Description 4	80	Final description of a file and its contents
Destruction Date	MM/DD/YYYY	Date on which the file is to be or was destroyed by Iron Mountain, based on customer instructions or calculated from the retention schedule of its record code
Create Date	MM/DD/YYYY	Date on which the file was added to the Record Center

Field Name	Maximum Characters	Description
Birth Date	MM/DD/YYYY	Date of the person documented in the file
Discharge Date	MM/DD/YYYY	Date of discharge from a health care or other facility of the person documented in the file
Social Security Number	Nnnnnnnnn	U.S. Social Security Number of the person documented in the file (do not use dashes)
Alpha From	10	Beginning of a customer-defined alphanumeric sequence by which the file is classified
Alpha To	10	End of a customer-defined alphanumeric sequence by which the file is classified

Insurance Files (Type 1 for Claims & Policies)

Field Name	Maximum Characters	Description
SKP Box Number	11	Bar code number, provided by Iron Mountain, that identifies a box
Customer Box Number	11	Customer-defined alphanumeric identifier for the box
Claim/Policy	15	Customer-defined alphanumeric identifier of the claim or policy
Office	6	Alphanumeric identifier of the office from which the claim or policy originates or is associated
Symbol	4	Alphabetic identifier preceding the policy number that identifies the type of insurance (e.g. WC for Workers Compensation)
Name	35	Name of the claim or policy holder
Expiration Year	2	Two-digit designation of the year in which the claim or policy expires
Type	3	Alphanumeric identifier for the business coverage category (e.g. Fire or Commercial Package insurance)

Field Name	Maximum Characters	Description
EIS	2	Alphanumeric identifier for the type of claim or policy generated by an Electronic Insurance System (e.g. G2 for General Liability)
Destruction Date	MM/DD/YYYY	Date on which the file is to be or was destroyed by Iron Mountain, based on customer instructions or calculated from the retention schedule of its record code
Alpha From	10	Beginning of a customer-defined alphanumeric sequence by which the file is classified
Alpha To	10	End of a customer-defined alphanumeric sequence by which the file is classified
Claim/Policy Indicator	1	Single letter or digit indicating whether this is a claim or policy file

Insurance Files (Type 2 for Claimants)

Field Name	Maximum Characters	Description
SKP Box Number	11	Bar code number, provided by Iron Mountain, that identifies a box
Customer Box Number	11	Customer-defined alphanumeric identifier for the box
Insured Name	35	Name of the insured party
Claimant Name	35	Name of the claimant
Loss Date	MM/DD/YYYY	Date on which the loss related to the claimant occurred
CCL	7	Alphanumeric identifier of the Claim Class Letter for the claim or policy
Destruction Date	MM/DD/YYYY	Date on which the file is to be or was destroyed by Iron Mountain, based on customer instructions or calculated from the retention schedule of its record code
Alpha From	10	Beginning of a customer-defined alphanumeric sequence by which the file is classified

Field Name	Maximum Characters	Description
Alpha To	10	End of a customer-defined alphanumeric sequence by which the file is classified

Legal Files

Field Name	Maximum Characters	Description
SKP Box Number	11	Bar code number, provided by Iron Mountain, that identifies a box
Customer Box Number	11	Customer-defined alphanumeric identifier for the box
Lawyer 1	4	Customer-defined alphanumeric code for the primary lawyer handling the case
Lawyer 2	4	Customer-defined alphanumeric code for another lawyer handing the case
Client Name	30	Name of the client of the case
Client Number	10	Customer-defined alphanumeric code for the client of the case
Matter Number	12	Customer-defined number identifying the legal matter
Letter	1	Single alphabetic letter used to organize this file in relation to other files
Sub Number	3	Customer-defined secondary number identifying the legal matter
Matter Description	45	Description of the case of legal matter
Close Date	MM/DD/YYYY	Date on which the legal matter was closed, if applicable
Number of Files	2	Number of files that are a part of this legal matter
Type	3	
Destruction Date	MM/DD/YYYY	Date on which the file is to be or was destroyed by Iron Mountain, based on customer instructions or calculated from the retention schedule of its record code

Field Name	Maximum Characters	Description
Alpha From	10	Beginning of a customer-defined alphanumeric sequence by which the file is classified
Alpha To	10	End of a customer-defined alphanumeric sequence by which the file is classified

Loan Files

Field Name	Maximum Characters	Description
SKP Box Number	11	Bar code number, provided by Iron Mountain, that identifies a box
Customer Box Number	11	Customer-defined alphanumeric identifier for the box
Loan Number	15	Customer-defined alphanumeric identifier for the loan
Old Loan Number	15	Customer-defined alphanumeric identifier previously applied to the loan
Borrower Name	26	Name of the borrower of the loan
Cost Center	5	Customer-defined alphanumeric code assigning the loan service costs to a cost center
File Type	1	Single letter or digit code used to organize this file in relation to other files
Acquisition Code	3	Alphanumeric code for a group of loans purchased from another financial institution
Destruction Date	MM/DD/YYYY	Date on which the file is to be or was destroyed by Iron Mountain, based on customer instructions or calculated from the retention schedule of its record code
Alpha From	10	Beginning of a customer-defined alphanumeric sequence by which the file is classified
Alpha To	10	End of a customer-defined alphanumeric sequence by which the file is classified

Medical Files

Field Name	Maximum Characters	Description
SKP Box Number	11	Bar code number, provided by Iron Mountain, that identifies a box
Customer Box Number	11	Customer-defined alphanumeric identifier for the box
Patient Number	9	Customer-defined alphanumeric identifier for the patient whose care is documented by the file
Birth Date	MM/DD/YYYY	Date of birth of the patient
First Name	12	First name of the patient
Last Name	14	Last name of the patient
Entry Year	2	Last two digits of the year that the patient entered treatment at the applicable office or health care facility
Destruction Date	MM/DD/YYYY	Date on which the file is to be or was destroyed by Iron Mountain, based on customer instructions or calculated from the retention schedule of its record code
Alpha From	10	Beginning of a customer-defined alphanumeric sequence by which the file is classified
Alpha To	10	End of a customer-defined alphanumeric sequence by which the file is classified

Module Five: Setting Preferences in the Record Center

There are two functions available from the Preferences menu: General Preferences and Search Preferences that can be set by each individual user.

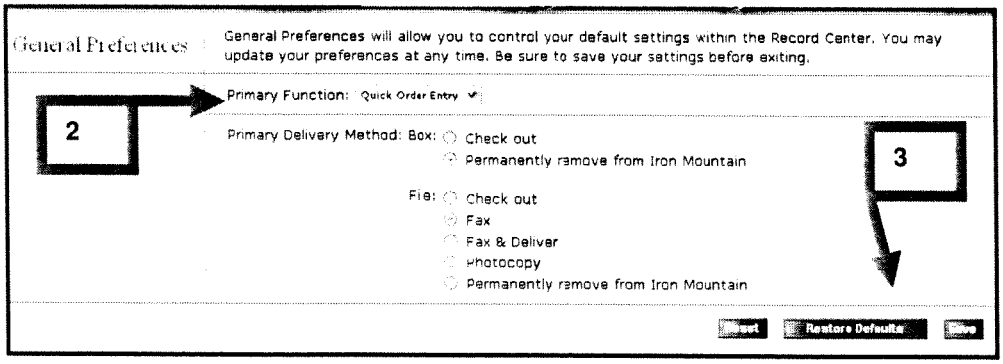
- General Preferences specify the default search method, delivery method, and quick order entry for your Record Center sessions.
- Search Preferences include settings that limit your searches to selected organizations, record types, record statuses, and other criteria.

General Preferences

1. Click Preferences and select General Preferences:

The system displays the General Preferences screen.

2. Click/select from the following:
   - Select a Primary Function (a menu option) from the drop down list.
   - Select one of the Primary Delivery Method radio buttons.
   - Select a File status option from the checklist.
3. Click Save



Note: The options available depend on privileges granted according to your security status.

Search Preferences

1. Click Preferences and select Search Preferences:

The system displays the Search Preferences screen.

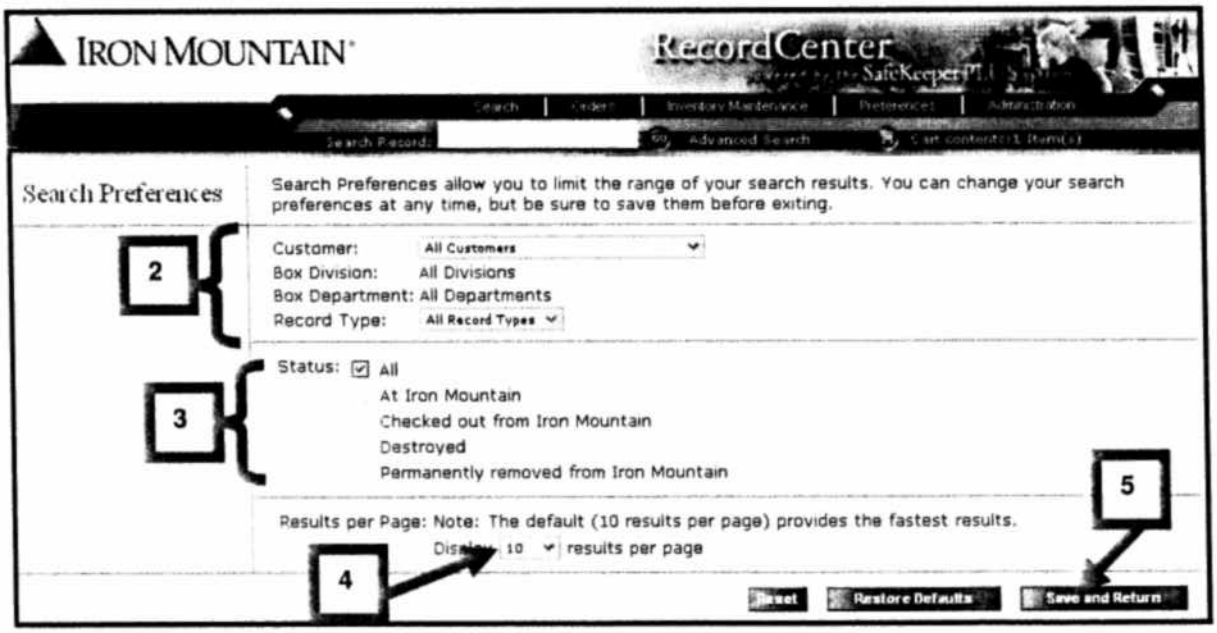
2. Select the desired item from each of the following drop down lists:

   - Customer
   - Box Division
   - Box Department
   - Record Type

3. Check the desired Status for your search

4. Click in Display box and select number of results per page

5. Click Save and Return



Note: The options available depend on your security level.

Module Six: The Report Center

Reporting

There are four different report categories available within the Iron Mountain Connect™ system; Activity, Inventory, Retention, and Financial.

- Within each of the categories you can access additional reports that assist you with budgeting, forecasting, and general information regarding your records management information.
- Reports are available in different formats; CSV, PDF, and XML. Reports are available within approximately two business days from the time ordered and will be automatically posted on your homepage in the Report Center section. Reports will remain posted for approximately 30 days and then automatically removed.
- If you would like to keep the report permanently, right click on it and save it. If you do not see the report you would like, contact your Account Manager or Iron Mountain directly; they can work with you to customize a report specific to your needs.
- All reports are free of charge.

The following are the four main report categories, their description and number of reports available under each category.

Report Category	Description	Number of Available Reports
Activity	User data, participation analysis, and activity history	6
Inventory	Snapshots and historic details of carton and file inventory, and other settings	11
Retention	Detailed and summary information related to records classification, retention schedules, hold codes, and destruction eligibility	5
Financial	Summary activity and projected forecasts, invoice history, and activity tied to dollars spent	1

Request a Report

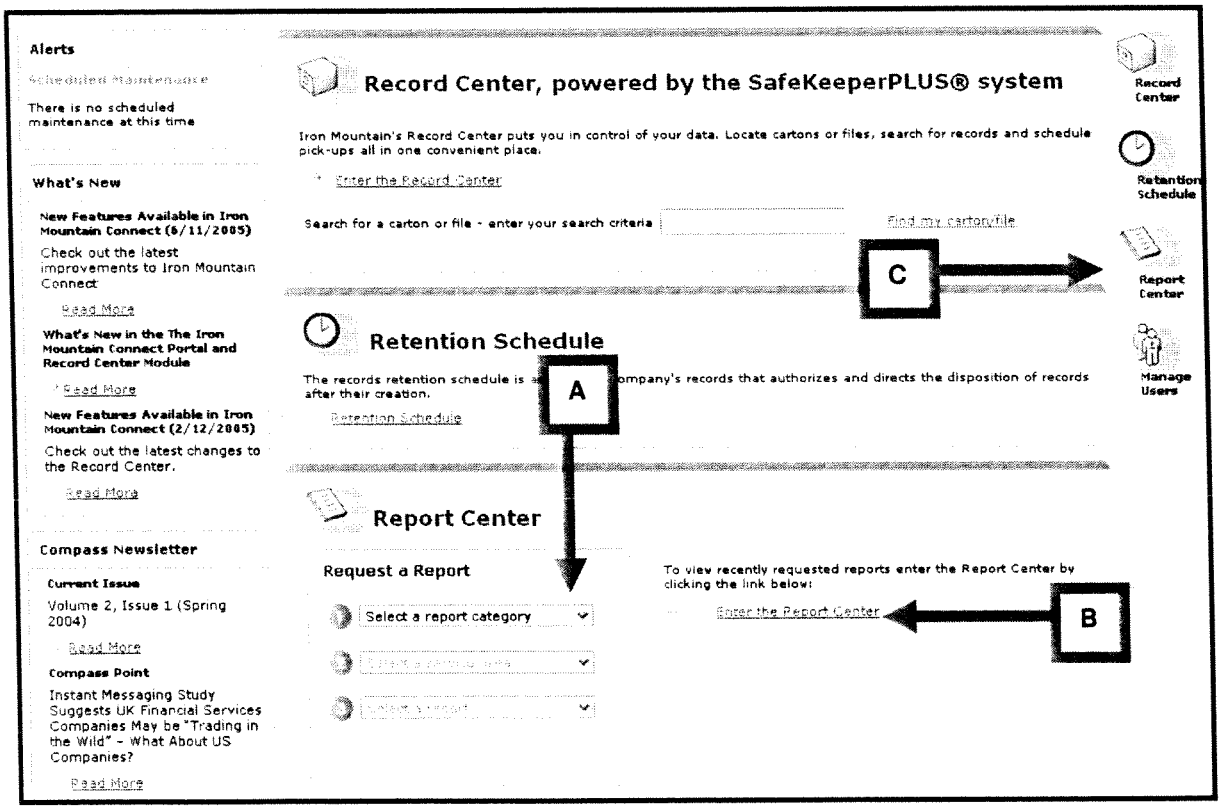
There are three different ways to enter the Iron Mountain Connect™ Report Center from the Home page and order reports. Follow these steps:

1. Enter the Report Center. You have three access points:

   A. Click in each Request a Report box (report category, service area, and report) and select applicable criteria

   B. Click Enter the Report Center link

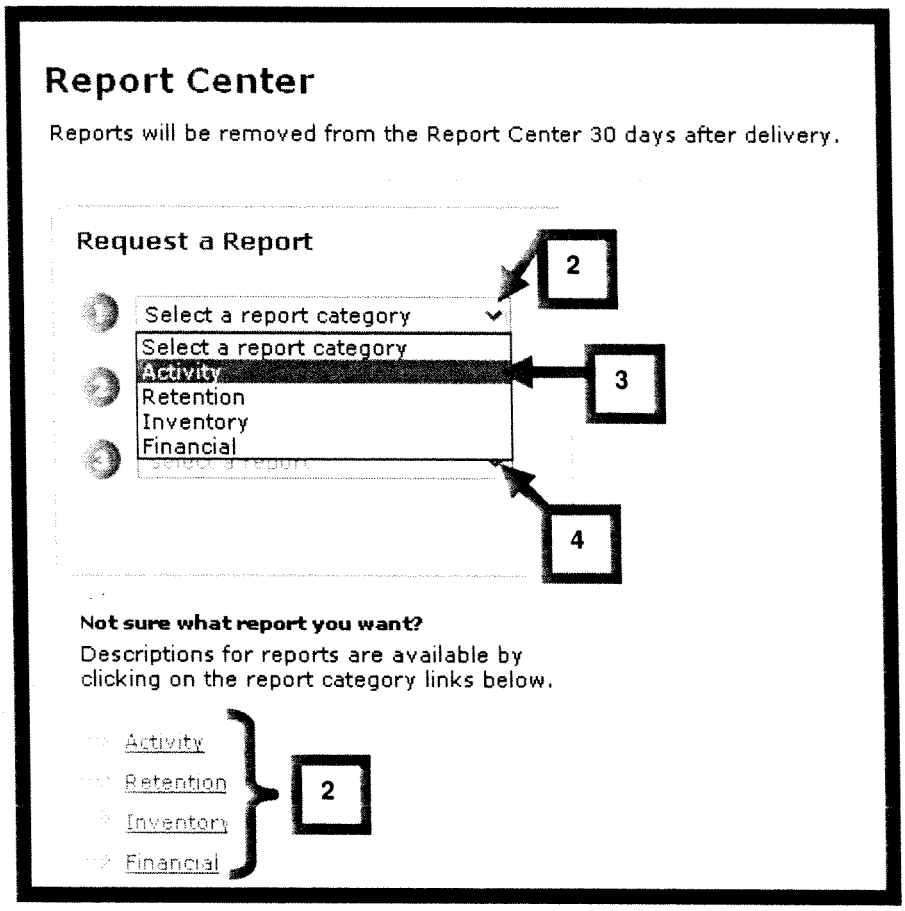
   C. Click Report Center icon



The system displays the Report Center screen which is initially the same as the Request a Report box above.

2. Select a report category from the drop down list.

Note: If you are not sure of the report you would like, for a detailed description of what each report consists of, select a report category link.



The system displays a list of Activity Reports.

3. Select Report Center from the Service Area drop down list (this is currently the only option available).

4. From list of Available Reports, select report category and click Request:

The system displays the Retrieval History Report specific details page.

Type of Report	Report Name	Description
Activity Report	Account List	Volume and contact information for active Iron Mountain accounts
	Activity by Location	Summary of ordering activity by location, quantity and order type
	Cubic Foot Summary Snapshot	Summary of box information including type, description, quantity and cubic footage
	Record Center User Report	Displays all Record Center users who can access the selected Customer/Division/Department. Displays access points for the user and the associated privileges
	Retrieval History	Activity history for outcarded, permanently withdrawn and destroyed inventory
	Storage Growth Analysis	Detailed storage breakdown with inventory growth analysis
Retention Report	Destruction Eligibility Forecast	Forecast of carton volumes eligible for destruction review; highlights the number of cartons without assigned destruction review dates. Provides a planning tool that allows destruction program analysis and forecast destruction expenditures
	Destruction Eligibility List	List of all cartons stored with Iron Mountain that are eligible for destruction review as of report request date
	Held Carton Summary	Summary of all records with a current hold status, including both hold codes and destruction indicators
	Record Classification List	List of record classes set up in SafeKeeperPLUS and their associated settings
	Record Classification Summary	Detailed summary of your record classes and the quantity of cartons associated with each
Inventory Report	Accounting File Inventory	Detailed review of active accounting files and their associated descriptive information
	Carton Date Summary	Carton quantities by year for each of the dates associated with carton inventory

Type of Report	Report Name	Description
	Carton Descriptive Details	Detailed list of descriptive data in SafeKeeperPLUS.
	Carton Inventory	Current inventory report for all cartons stored with Iron Mountain
	File Inventory	Detailed review of active files and their associated descriptive information
	Insurance File 1	Detailed review of active insurance files and their associated descriptive information
	Insurance File 2	Detailed review of all active insurance files and their associated description information
	Inventory Ownership Summary	Detailed review of the quantity of carton and files for division and department
	Law File Inventory	Detailed review of active law files and their associated descriptive information
	Loan File Inventory	Detailed review of active loan files and their associated descriptive information
	Medical File Inventory	Detailed review of active medical files and their associated descriptive information
Financial Report	Cost and Activity	Billing activity for specified invoice period

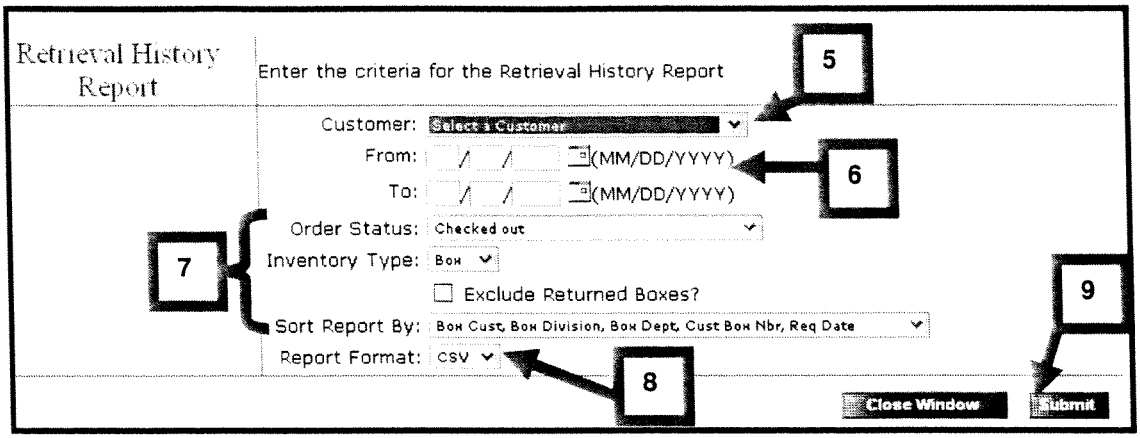
5. Select a Customer ID, division and/or Account from the drop down list.

6. Type date in the From/To boxes, or click on the calendar icon and select dates

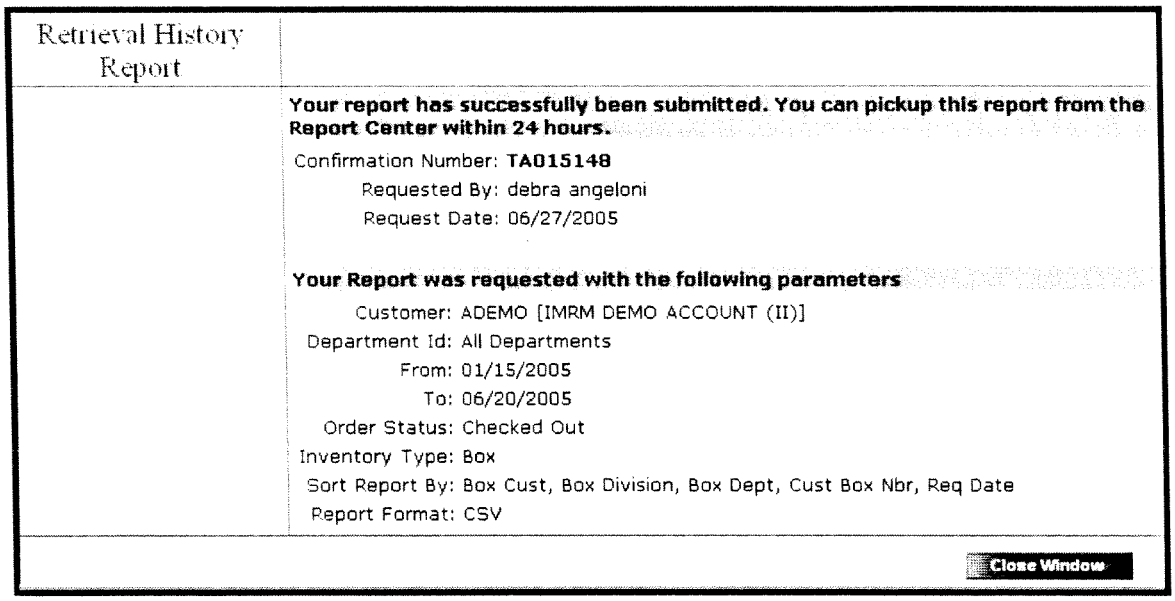
7. Select any other criteria applicable to report requested

8. Select Report Format from the drop down list: .pdf, cvs (Excel worksheet) or .xml (see sample for a Retrieval History Report below)

9. Click Submit.



The system displays the Report Confirmation screen.



After requesting the report, return to the Report Center at a later time to retrieve the report.

Note: reports are available in the Report Center for 30 days only at which time they will be deleted. To retain a report, save it to a local or network drive on your computer.

Module Seven: Administrator Functionality

There are four different administrator roles within Iron Mountain Connect. Your company may want to assign one or more individuals with Administrator privileges.

A definition of each administrator is listed below. Administrators have special security privileges, therefore; Iron Mountain recommends keeping the number of administrators to a minimum.

All administrator privileges assigned to Iron Mountain Connect users must be approved by your company's authorized administrator.

Client User Administrators: These administrators have the following privileges:

- View content
- Access to the Records Center
- Create or modify the end user
- Create or modify the User Administrator
- Create or modify the Content Administrator
- If the Client User Administrator has an assigned business group, he or she can only add or edit users in that specific business group

Client Content Administrators: These administrators have the following privileges:

- View content
- Access the Records Center
- Upload client content

Account Managers: These administrators have the following privileges:

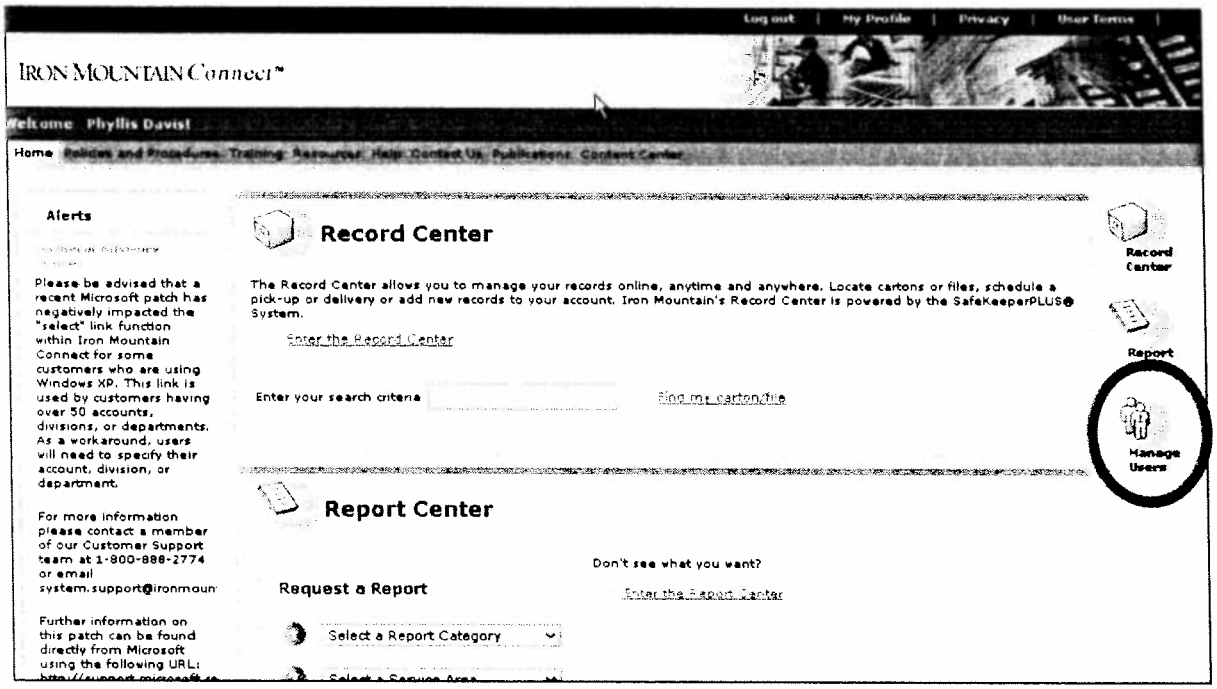
- View content
- Access to the Records Center
- Belong to more than one company group
- Upload client content
- View users for their company but CANNOT edit users

IMC Administrators: These are the top level administrators and have the following privileges:

- View Content
- Access to the Records Center
- Upload Client Content
- Upload Iron Mountain Content
- Upload Retention Schedules
- Create and Modify End Users
- Create and Modify User Administrators
- Create and Modify Content Administrators
- Create and Modify Account Managers
- Create and Modify IMC Administrators
- Edit User Status
- Assign Any Report Group
- Assign My Report Groups

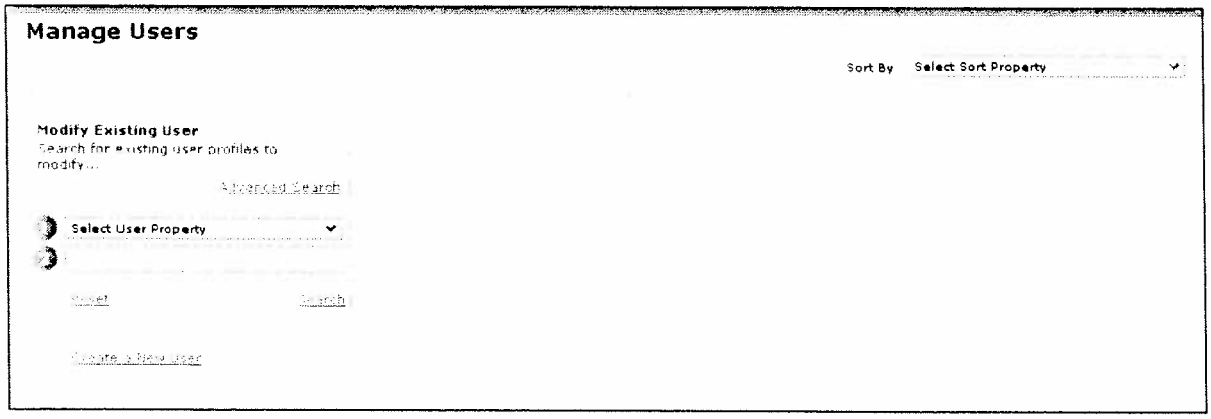
Client User Administrator

Go to the Homepage and click on the Manage Users icon or scroll to the bottom of the page.



You have two options:

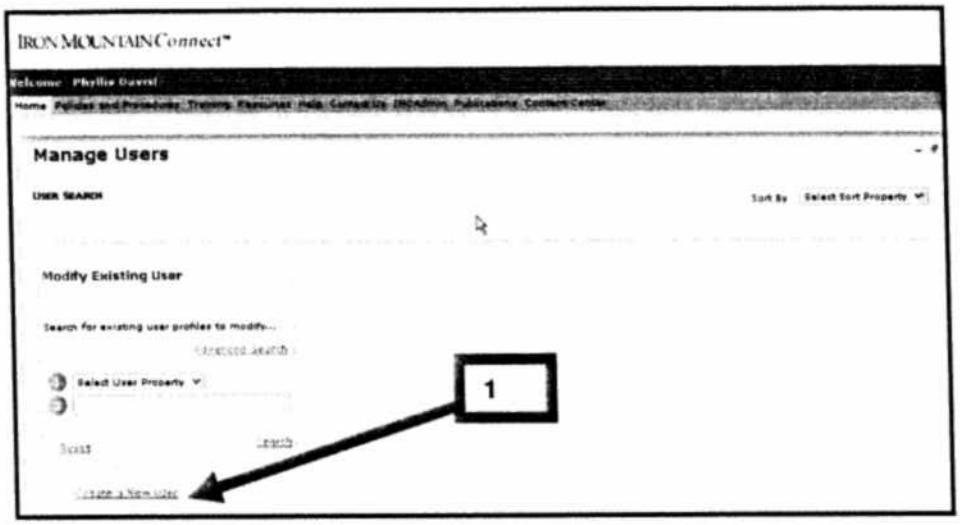
- Modify an existing user
- Create a new user



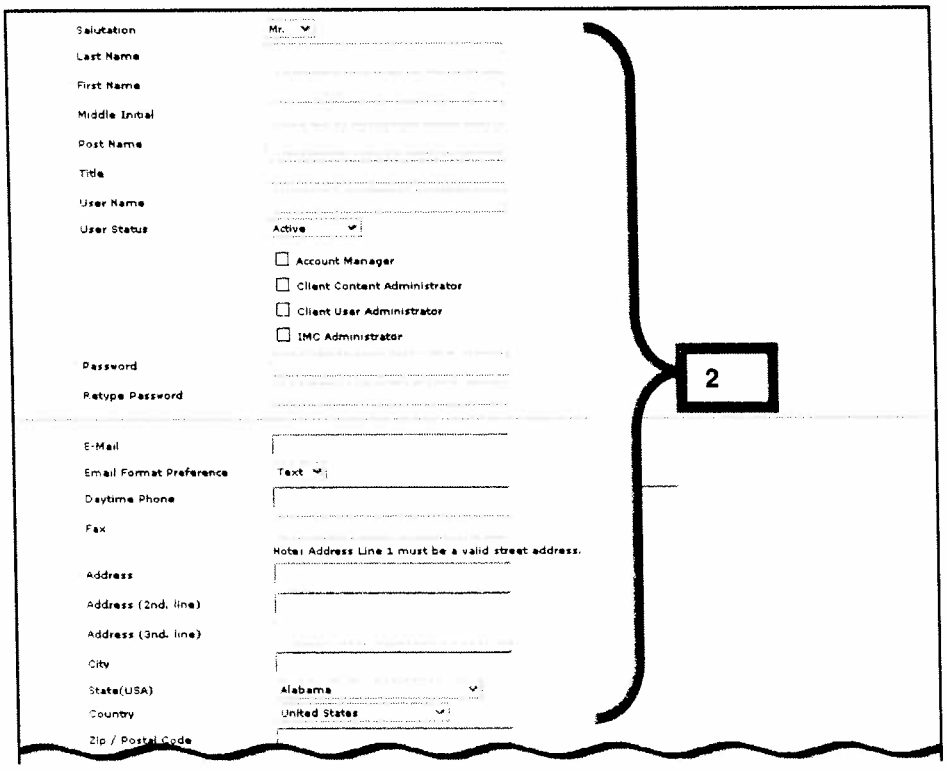
Create a New User and Set up Profiles

To create a new user and set up profiles, follow these steps:

1. Click on Create a New User:



The system displays the Create a new user screen.



2. Fill out all general profile required fields (*) and click Submit at the bottom of the page.

Note: If you enter a username that has already been used, the system will automatically generate a username by appending a number to the one you originally entered. The system will display a message noting the change.

If all fields have been completed properly, a message will display that you have successfully created a new user.

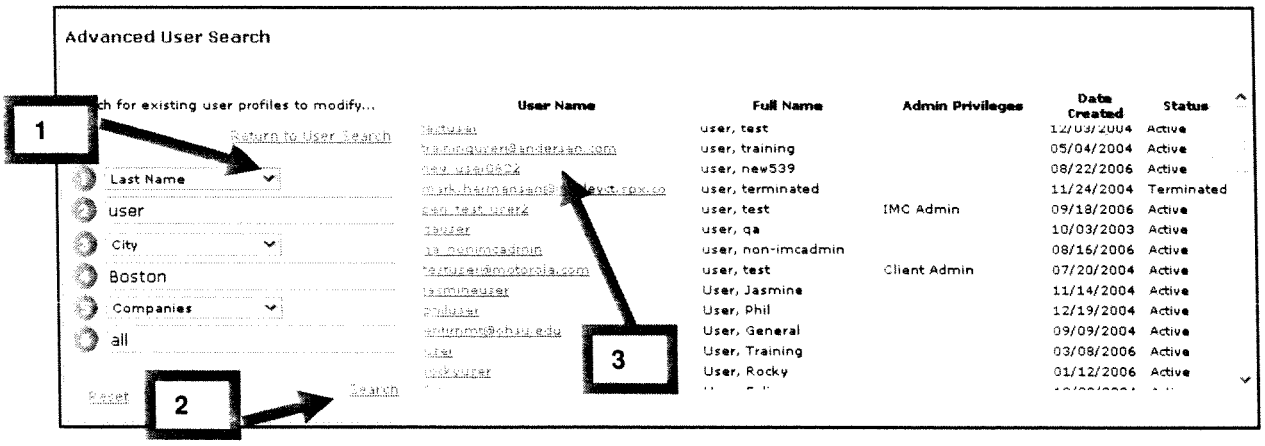
Search For and Modify Existing User

In order to view or modify an existing user, you must first search for an existing user.

1. You can either do a basic search by selecting one user property and entering the value or do an Advanced User Search, allowing you to set up to three selection criteria.

Note: You must enter the entire search term; a partial term will not return any results.

2. Click Search.



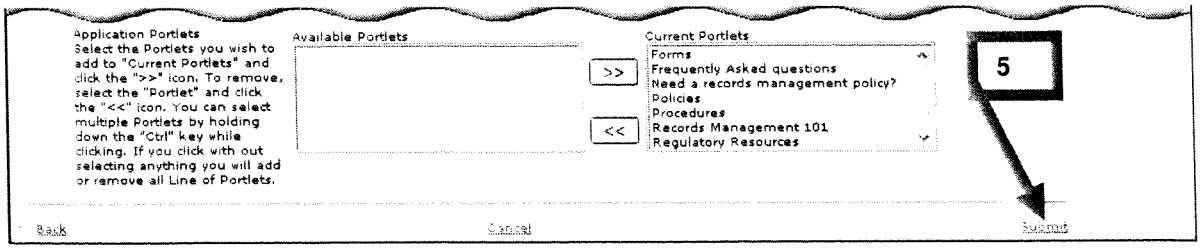
The search results will be displayed on the right hand side of the screen.

3. Select the user to be modified.

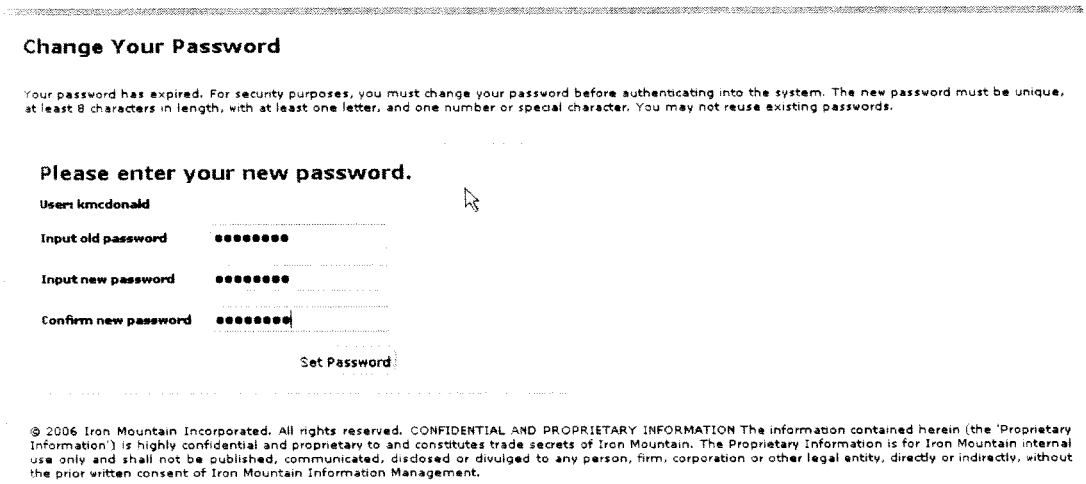
The screen that appears is the same that appears when creating a new user.

4. Enter or modify applicable fields. The three sections at the bottom set permissions for the Report Groups, Lines of Business and Application Portlets to which the user will have access. See the table below for a list of the options available.

5. Click Submit.



If an administrator changed a user's password, the user will be prompted to reset his password on the next login.



See the table below for a summary of fields for setting up and modifying a user:

General Profile Information Summary

Label	Description	Required?
Salutation	Select Dr., Mr., Ms. or Mrs.	Yes
Last Name	User's last name – must be a person's name	Yes
First Name	User's first name – must be a person's name	Yes
Username	The user's username; this cannot be changed later	Yes
User Status	Select Active or Terminated Check the applications for which the user will be authorized	Yes
Password	The user's password	Yes
Retype password	Confirm password	Yes
E-mail	The user's e-mail address – must be a valid, unique e-mail address	Yes
E-mail format preference	Text or html	No
Daytime phone	The user's phone number	No
Fax	The user's fax number	No
Address (1st line)	The user's first address line	Yes
Address (2nd line)	The user's second address line	No
Address (3rd line)	The user's third address line	No
City	The user's city	Yes
State	The user's state (if outside the U.S., please select a different country in the Country dropdown)	Yes
Country	The user's country	Yes
Zip Code	The user's zip code	Yes
Preferred Language	Select from the drop down list (defaults to American English)	Yes

Time Zone	Select from the drop down list	No
Date Format	Select from the drop down list	No
Numeric Format	Select from the drop down list	
Report Groups	Select the report groups the user should be able to request from the Available report groups box and click Add: ⊞ ▸	No
Lines of Business	Select the lines of business to which the user will have access and click Add : ⊞ ▸	No
Application Portlets	Select the application portlets to which the user will be able to upload or delete content and click Add: ⊞ ▸	No

Password Lockout Rules

The first time new users access IM Connect, they will be required to change their passwords and create 5 security/challenge questions from a list of 10 available questions. If they forget their password or get locked out of the system, 3 of the 5 questions will be randomly chosen for response to unlock the user.

After 3 unsuccessful attempts to access an account, the account will be locked for 5 minutes. The user can then use the "Forgot Password" function to access his account and answer the challenge questions.

Once the challenge questions have been successfully answered, an email will be sent to the user's registered address with a temporary password that must be changed at the next log-in.

The username will unlock in approximately 5 minutes.

After each lockout, a user needs to wait 5 minutes to attempt entry. However, after one set of lockouts, the account will lock after only one unsuccessful attempt and the user will have to wait 5 minutes before another attempt. For this reason, it is better to use the "Forgot Password" function rather than making attempt after attempt to remember a password.

Client Content Administrator

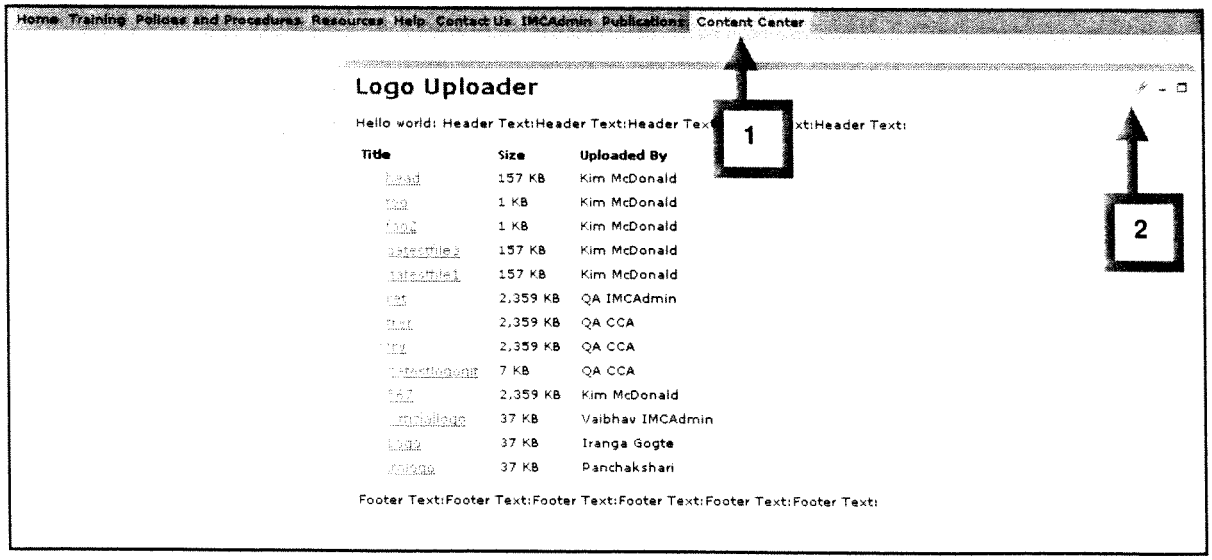
Adding/Uploading Logos

Client Content Administrators and ICM Administrators may upload company logos from the content center or other documents from each "Portlet" page by clicking on the paperclip icon.

Note: Only Logos can be uploaded from the Content Center. All other content is loaded from the specific Portlet. Look for the paperclip icon:

Policies	Terms and Definitions
Procedures	Forms
Tips and Best Practices	Regulatory Resources
Report Center Tutorials	Industry Resources
Record Center Tutorials	Records Management 101
Administrative Tutorials	Newsletters
Iron Mountain Connect Overview	IM Connect Frequently Asked Questions
Escrow Management Center Tutorials	Records Center Frequently Asked Questions
Iron Mountain Connect Training Materials	Report Center Frequently Asked Questions
Case Studies	White Papers

1. Click Content Center link from the Homepage to upload a logo:



The system displays the Logo Uploader screen.

2. Click on the paperclip to upload new logos.

Header / Footer

You may customize the header and footer logos and text that appear specifically for a company.

Note: By uploading your company logo you will automatically replace the Iron Mountain Connect page header, the image to the right of IM Connect logo, with your company's logo.

You can only display one image. If you upload a second image, only the first image in the list will be displayed. You can only upload files in either a .gif or .jpg format. We recommend uploading a logo with the following dimensions: 1.57 x .20 inches (or 467 x 60 pixels). Images that are not this size will be sized to fit the space. This may result in a distortion of your company logo.

Current Document List

A list of all the currently uploaded documents is displayed in the center portion of the Logos screen. Only the topmost logo will be displayed even if multiple logos have been uploaded.

Click in the checkbox next to a file and click on Delete to remove a file.

Update / Post Documents

Use this portion of the screen to upload the logo file to IM Connect.

1. Enter a title for the logo to be uploaded.

2. Select the company, language and country from the drop down lists. You can select multiple countries by holding the shift key down while clicking on a country name.

4. Select the Line of Business from the drop down list. You can select multiple lines of business by holding the shift key down while clicking on the line of business.

5. Click the Browse link next to File to search for the file to be uploaded.

6. Click Submit File to complete the upload.

Logo Uploader

Selected File(s) deleted successfully.

HEADER/FOOTER

Language: English **Company:** large_company

Header Text:
Hello world: <%= new java.util.Date().toString() %>

Header Text:Header Text:Header Text:Header Text:Header Text:

Footer Text:
Footer Text:Footer Text:Footer Text:Footer Text:Footer Text:Footer Text:

No Files Message:

Update Header/Footer

CURRENT DOCUMENT LIST

Title	File Name	Size	Date Uploaded	
qatestlogogif	card_id_number.gif	7 KB	2006-08-31	☐
try	newuserlogin.bmp	2,359 KB	2006-09-01	☐
qatestfile1	basic ie settings.doc	157 KB	2006-09-11	☐
ret	companyname.jpg	2,359 KB	2006-09-11	☐
foo	foo.jsp	1 KB	2006-09-19	☐

Delete Selected

UPDATE/POST DOCUMENTS

Post or update documents below. Browse the file you'd like to upload and then click "submit."
Upon submission, the document will appear in the current documents listing above:

Title: 1

Company: large_company

Language: English

To select multiple Countries, hold down the Shift or Control key.

Country:
American Samoa
Argentina
Aruba
Australia
Austria

2

To select multiple Lines of Business, hold down the Shift or Control key.

Line of Business:
Domain Name Center
Enterprise Retention
Escrow Management
Records Management
Secure Shredding

3

File: Browse... 4

Submit File 5

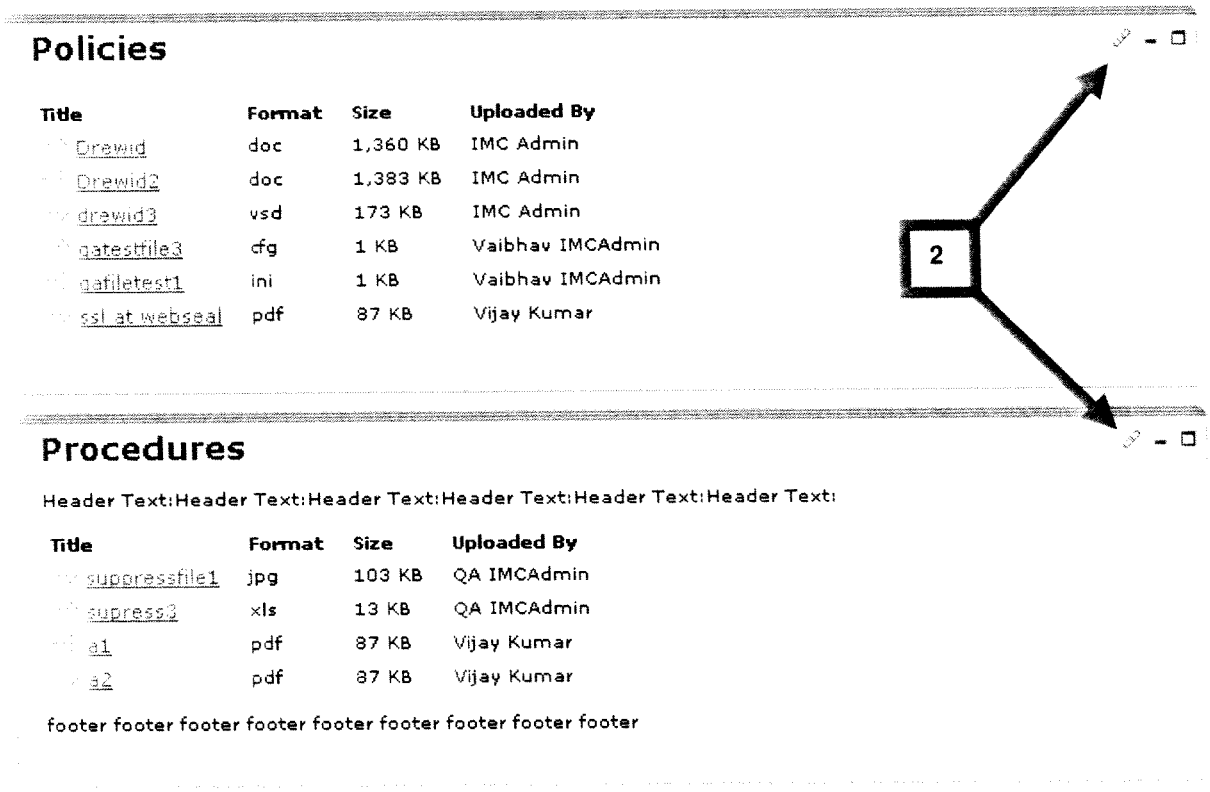
(File will appear in the list above)

Uploading to Other Portlets

You may also upload content to many of the other portlets within IM Connect.

1. Click on the desired region from the top menu bar. The example below is for uploading to the Policies and Procedures page.

2. Click on the paperclip in the top right corner of region to open the upload page.



3. Complete the Update / Post Documents region to post documents.

4. Click Browse to locate the file.

5. Click Submit File to complete the upload.

Deleting Content

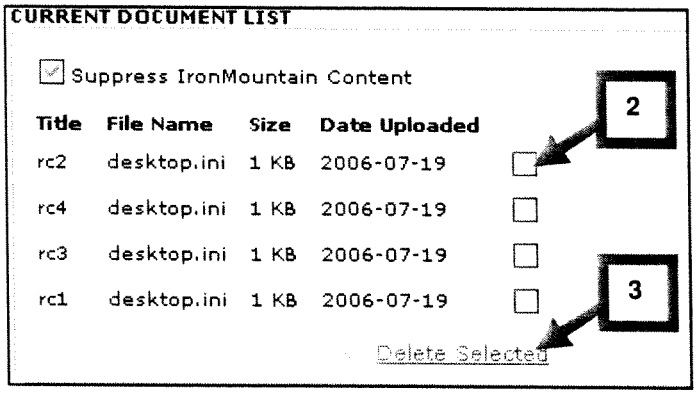
In order to delete content, you must return to where you uploaded the content. To remove logos, go to the Content Center. To remove other documents, go to the area to which the document was uploaded, such as Policies and Procedures or Resources.

1. Once in the area where you want to delete content, click on the paperclip at the upper right part of the screen.

2. In the next window, scroll down to the Current Document list.

2. Click in the checkbox next to the document or documents you wish to delete.

3. Click the Delete Selected link. All selected documents will be removed from that region.



Administering the Records Center

Within the Record Center, there is an administrative component for setting permissions for specific activity within IM Connect.

Viewing Your User Profile

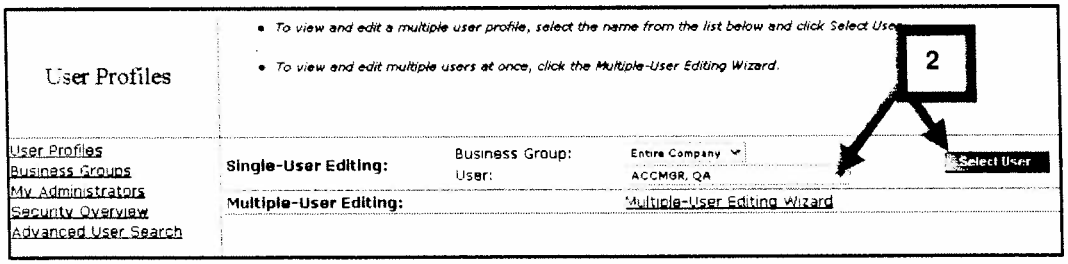
The User Profile screen displays the functions and organizations to which you are granted access (in the Record Center).

Note: Standard Users can view their own profiles only. IMC Administrators can view and edit the profiles of all Administrators and Users in the enterprise (Iron Mountain customer). Business Group Administrators can view and edit the profiles of Business Group Administrators and Users in their Business Groups.

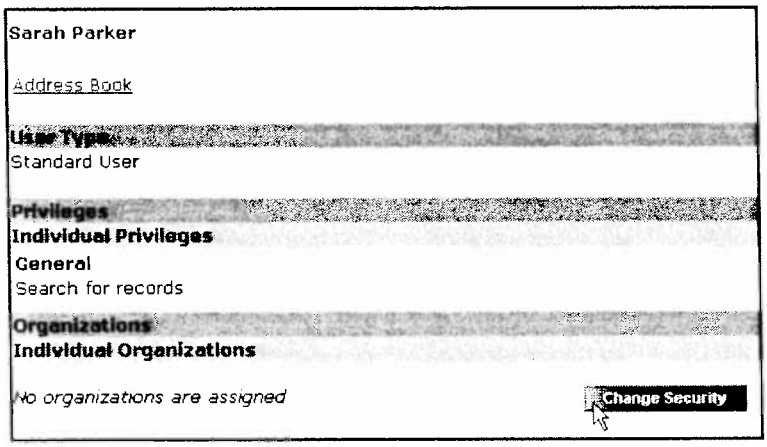
To view your User Profile, follow these steps:

1. Click Administration and select Security from the drop down menu

2. From the User Profiles screen, click Select User or search for a user from the drop down list.



The system displays your current User Type, Privileges, and Organizations.



Editing User Profiles

You can edit single user and multiple users' profiles.

- Enterprise Administrators are authorized to edit User Profiles of Business Groups, Business Group Administrators, other Enterprise Administrators, and all Standard Users.

- Business Group Administrators are authorized to edit User Profiles of Business Group Administrators and Standard Users within their own Business Groups only.

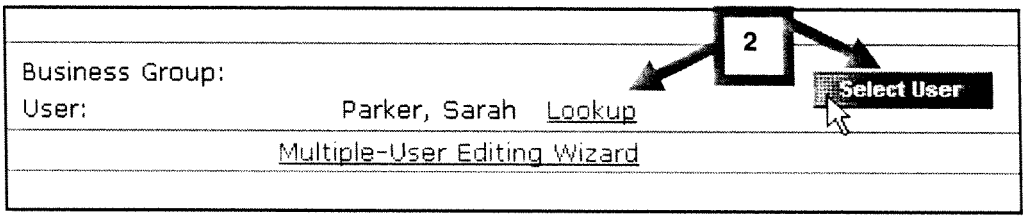
To edit single User Profiles:

1. Click Administration and select Security from the Administration drop down menu

The system displays the User Profiles screen.

2. Click Lookup to display the User Lookup screen.

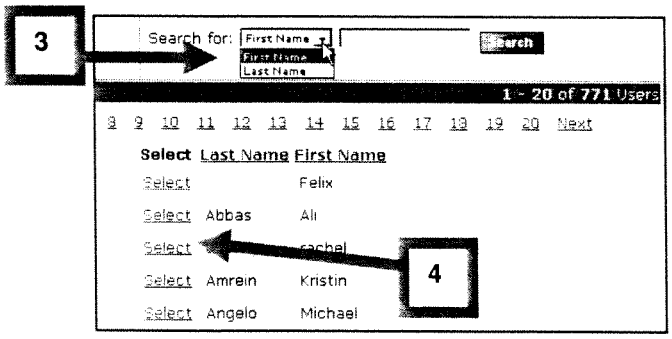
Note: if the correct name is already displayed, click Select User to bypass steps 3 and 4.



3. Select First Name or Last Name in Search For box, type the name in the Search box, and click Search.

4. Click Select next to the user name requested

Note: You can also click the page number links or the Next link to scroll through user names.



Note: The User Lookup screen is only available for companies with 50 or more users. If the company has fewer than 50 employees, the user names are displayed in a drop list on the User Profiles screen.

The system displays the User Profiles screen with the selected User's name.

6. Click Change Security to edit the selected User's profile:

The system displays all available privileges and organizations.

7. In the Privileges section, select each privilege that you want to assign to the selected user

8. In the Organizations section, select each organization that you want to grant the selected user access and click Save Changes:

Note: If you know the name of the Customer, Division, or Department that you want to select (but are unsure of its location in the Individual Organizations structure), type its name in the Customer, Division, or Department entry fields and click Search. The Individual Organizations structure automatically opens to display any names matching your search criteria.

The system displays confirmation message across the top of the User Profile screen indicating that your changes have been saved.

Editing Multiple User Profiles

- Enterprise Administrators are authorized to edit User Profiles of Business Groups, Business Group Administrators, other Enterprise Administrators, and all Standard Users.

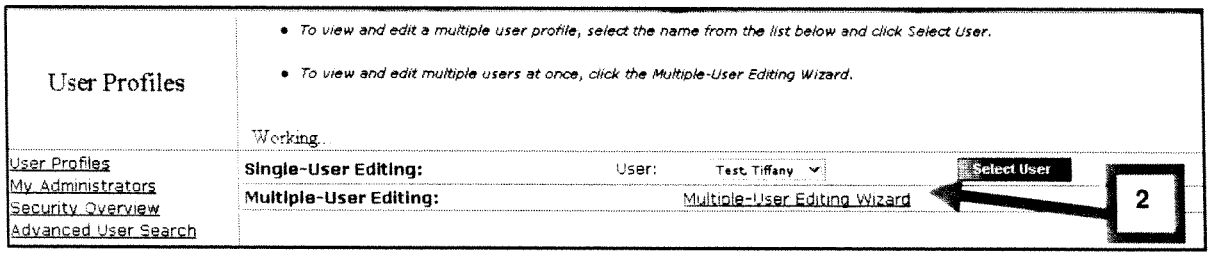
- Business Group Administrators are authorized to edit User Profiles of Business Group Administrators and Standard Users within their own Business Groups only.

To edit multiple User Profiles, follow these steps:

1. Click Administration and select Security from the Administration menu.

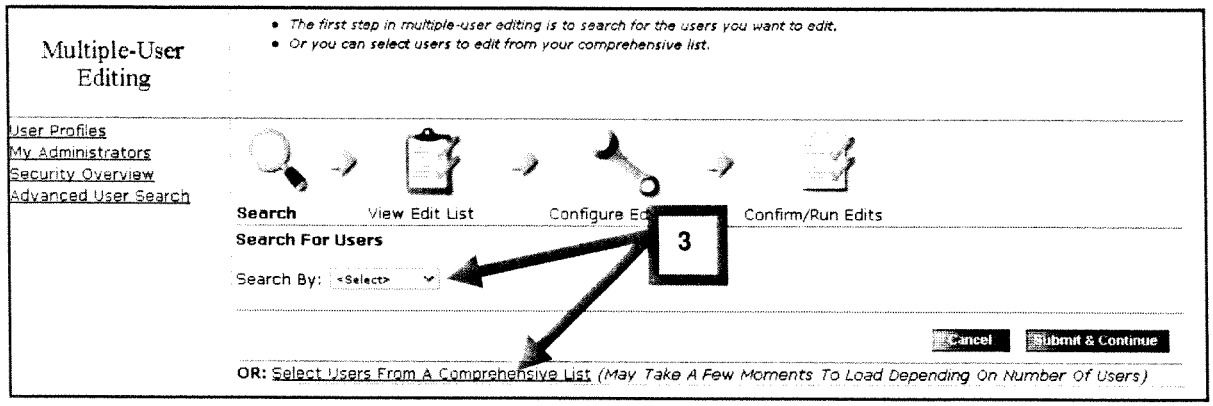
The system displays the User Profiles screen.

2. Click Multiple-User Editing Wizard:



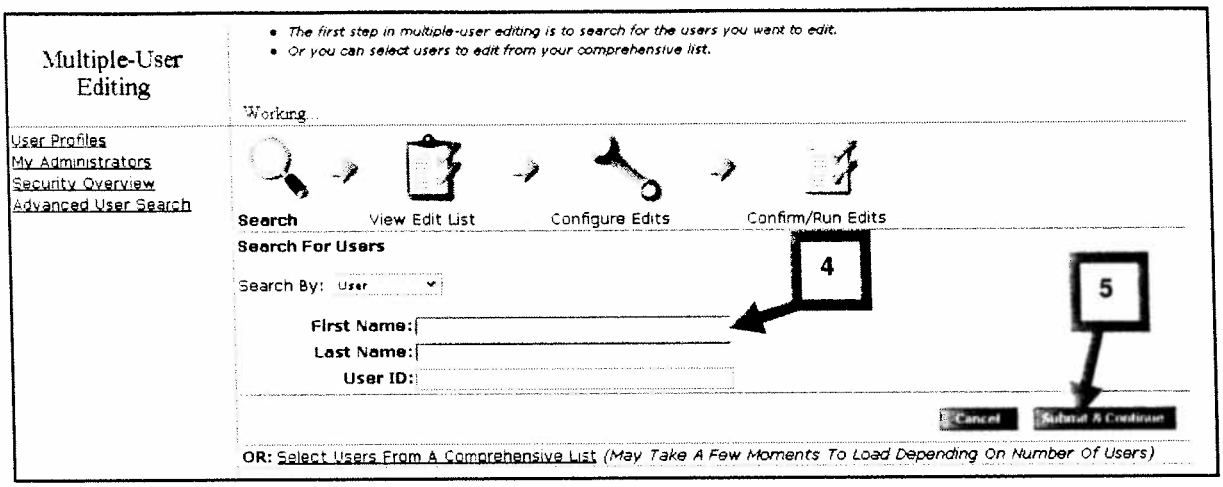
The system displays the Multiple-User Editing screen.

3. You can either click on Search By to set criteria to search for users or click on Select Users From A Comprehensive List link:



4. Select the parameters applicable to the selected search criteria. The options that display depend on the type of search: User, Organization or Privilege.

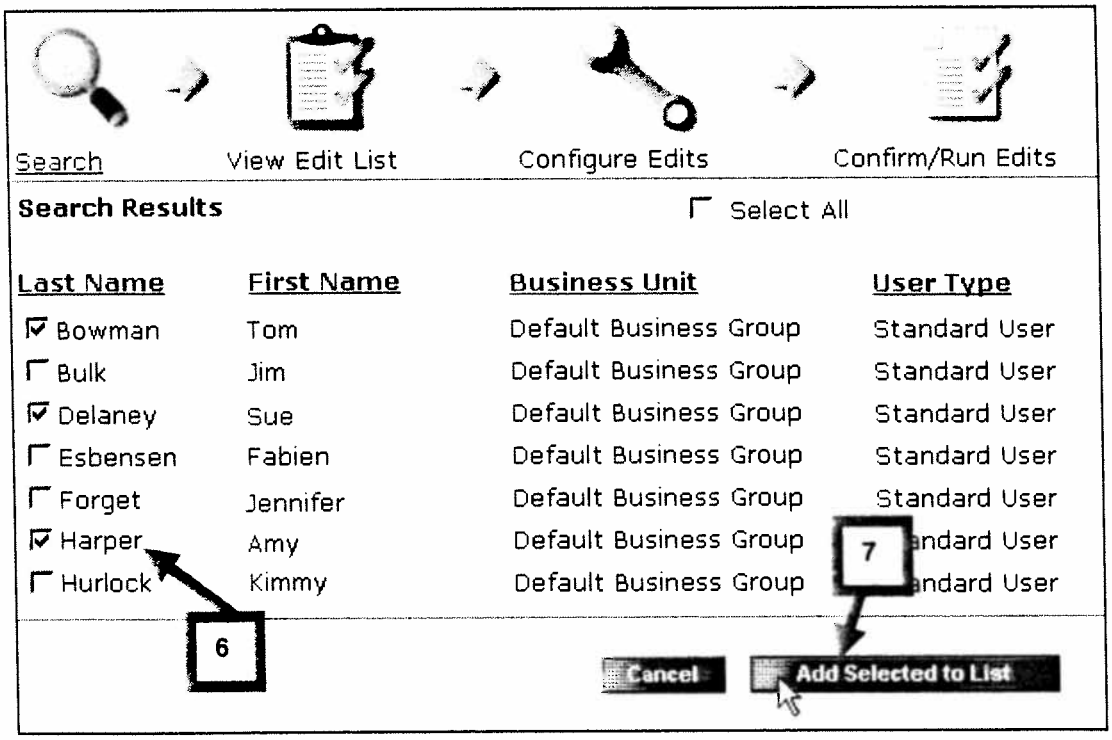
5. Click Submit & Continue.



The system displays the Search Results screen.

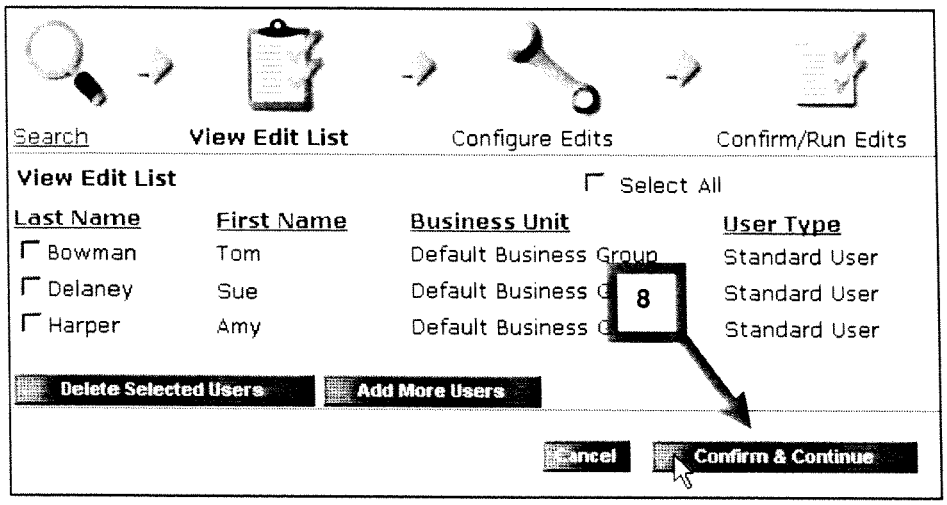
6. Select the users that you want to edit.

7. Click Add Selected to List.



The system displays the View Edit List screen.

8. Add or delete users if needed and click Confirm & Continue:



The system displays the Configure Edits screen.

9. Click Privileges and select Add or Remove:

10. In the Privileges section, select each privilege that you want to assign to the selected Business Group

11. In the Organizations section, select each organization that you want to grant the selected Business Group access.

12. Click Confirm Edit List & Continue.

Configure Edits

Add Privileges

9

Individual Privileges

Select All

Administration

Copy addresses from Ship-to list
View division profiles
View record code profiles
Maintain divisions
Maintain record codes
Maintain shipping addresses
Access invoice information
View customer profiles
View department profiles
View hold code profiles
Maintain departments
Maintain hold codes
Update any user's orders

Records Data Management

Add files
Edit box metadata
Edit box retention data
Add boxes
Edit box organizational data
Edit file data

10

Service Options

Check boxes out
Order unlisted files
Order fax transmission of records
Order supplies
Permanently remove files from storage
Check files out
Order copies of records
Order pickup service
Permanently remove boxes from stora

<Select> Organizations

Individual Organizations

Search organizations

11

MCCF2 [BILLABLE CF TEST, BC=8,REMIT=1]
RAVEN [BALTIMORE RAVENS FOOTBALL CLUB]

Selected Organization Summary

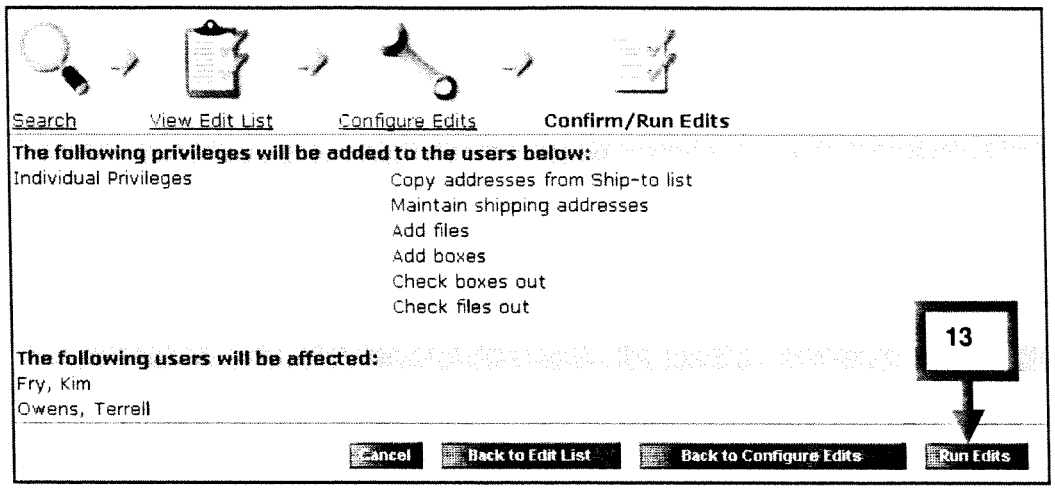
The following organizations will be added or removed from the users on the edit list.

12

No organizations have been selected

Cancel | Back to Edit List | Confirm Edit List & Continue

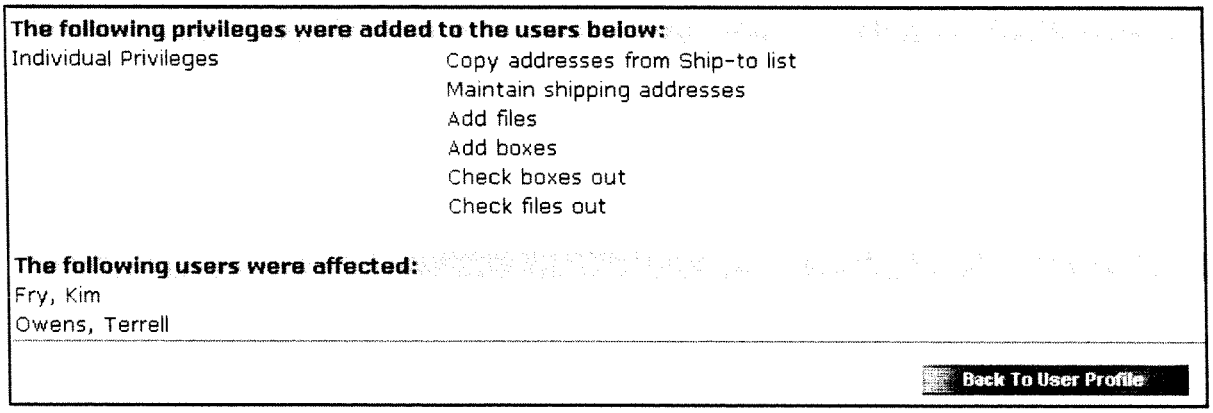
The system displays Confirm/Run Edits screen.



Verify that information displayed is correct.

13. Click Back to Edit List or Back to Configure Edits if you need to make changes. If satisfied with your edits, click Run Edits.

The system displays the Confirmation screen.



Note: For large Multiple User Editing requests, the following message displays across the top of the Confirm/Run Edits screen: "Due to the large nature of your request, we are processing it in the background and will notify you when complete."

Field Name Customization

Administrators have the ability to customize the field names for the types of data captured about their inventory. The customized field names will be visible in the Search Results, Order screens and reports.

The customization has the benefit of allowing a company to better reflect its operations and terminology within both the Records Center and Report Center.

There are two types of customization:

- Drop down lists from which the Administrator can choose the most appropriate description
- Fully customizable field names.

The customization options that are available depend upon the type of file. See the table on page 95 for a full list of options.

Note: System Support must first enable a customer for this service. Once a customer is enabled at the Enterprise level, the Administrator can limit functionality to one account, multiple accounts or all accounts. The Business Group Administrator can also enable or disable the functionality for a specific customer account.

1. Click Administration and select Data Parameters:

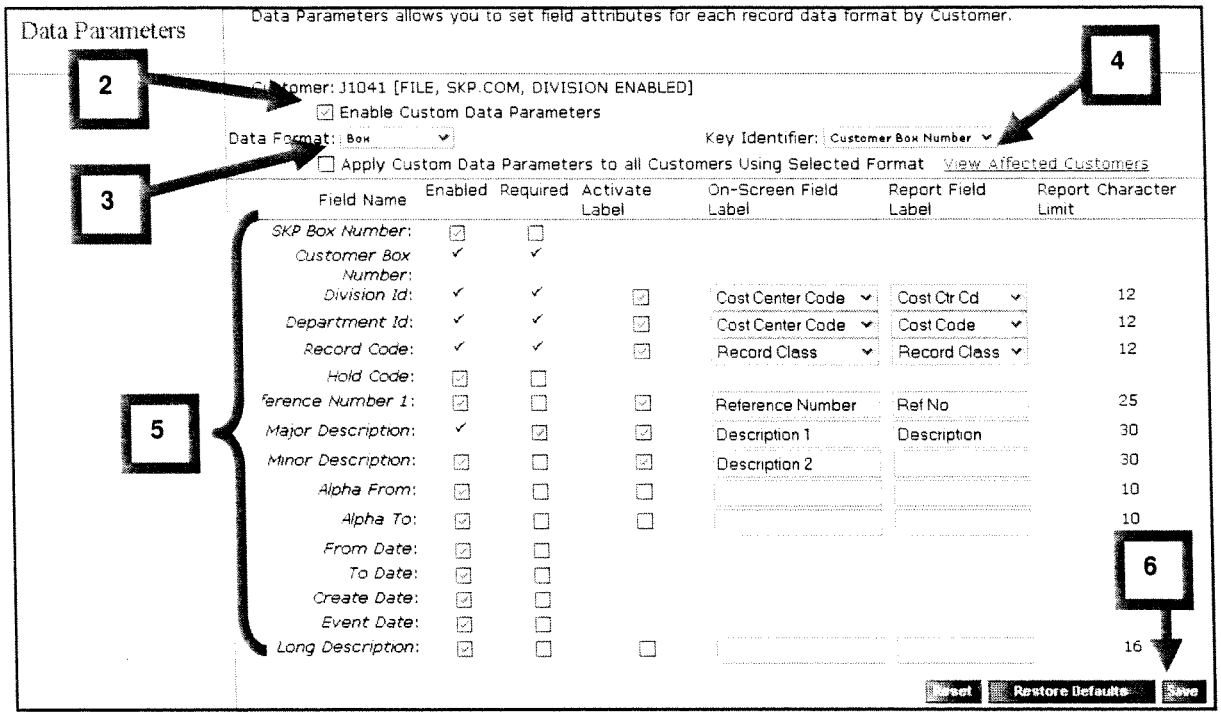
2. Make sure Enable Custom Data Parameters has been checked.
3. Select the Data Format from the drop down list.
4. Select a Key Identifier from the drop down list (options depend upon the type of Data Item).

Note: If the account has multiple customers, you can apply the customization to all customer accounts by clicking in the check box.

5. Configure each data field by checking the appropriate boxes:
   - Enabled: the field will be available for data entry
   - Required: an entry must be made in the field in order to save the information for the specific file
   - Activate Label: once checked, either select a label from the drop down list for the on-screen field label and report field label or enter a free-text description for each. Report

header character lengths are displayed in the far right column. If left unchecked, the Field Name description from the left hand column will be displayed on the screen and on reports.

6. Click Save to save your settings.



Note: The Department ID, Division ID and Record Code fields can only be changed to one of the options from the drop down list. Free text entries are not supported for those fields.

Customizable Fields—Drop Down List Options			
Field Name	**Field Label**		
Department Id	Cost Center Code Cost Code Disbursement Code GL Code	Office Number Project ID Site ID Transit	Unit Code Oracle Number Billing Code
Division ID	Cost Center Code Department ID	Geography	Unit Code
Record Code	Box Code Record Class	Record Number Record Series	Retention Period Series ID

Modifiable Fields by Data Type			
Data Type	**Fields**		
Accounting File	Accounting Client Name Client Number From Date	To Date Destruction Date Alpha From	Volume Number Alpha To
Box	Hold Code Reference Number Major Description Minor Description	Alpha From Alpha To From Date To Date	Create Date Event Date Long Description
Standard File	File Description 1 File Description 2 File Description 3 File Description 4	Destruction Date Create Date Birth Date Discharge Date	Social Security Number Alpha From Alpha To Volume Number

Modifiable Fields by Data Type			
Data Type	**Fields**		
Insurance File 1	Claim/Policy Number Office Symbol Claimant Insured Name	Expiration Year Type EIS Destruction Date	Alpha From Alpha To Claim/Policy Indicator Volume Number
Insurance File 2	Insured Name Claimant Name Loss Date	CCL Destruction Date Alpha From	Alpha To Volume Number
Law File	Lawyer 1 Lawyer 2 Client Number Matter Number Letter	Sub Number Matter Description Close Date Number of Files Type	Destruction Date Alpha From Alpha To Volume Number
Loan File	Loan Number Old Loan Number Borrower Name Cost Center	File Type Acquisition Code Destruction Date	Alpha From Alpha To Volume Number
Medical File	Patient Number Birth Date First Name	Last Name Entry Year Destruction Date	Alpha From Alpha To Volume Number

Parameter Histories

The parameter history lists the changes to the data parameters of the selected data format and customer.

	Date	Time	Action	Modified By
Parameter History	08/31/2006	12:34:22 PM (EDT)	Custom Data Parameters Enabled	Saperstein, David
	08/31/2006	11:47:07 AM (EDT)	Custom Data Parameters Deactivated	Garner, Johnathan
	08/07/2006	09:31:55 AM (EDT)	Birth Date enabled removed	Deschane, Dick
	08/07/2006	09:31:55 AM (EDT)	Destruction Date enabled removed	Deschane, Dick
	08/07/2006	09:31:54 AM (EDT)	Patient Number enabled removed	Deschane, Dick

Action	Description
Change in key identifier value	Key identifier of the data format was changed
[field name] enabled	Field selected as enabled for data entry
[field name] required	Field selected as required for data entry
[field name] enabled removed	Field deselected as enabled for data entry
[field name] required removed	Field deselected as required for data entry

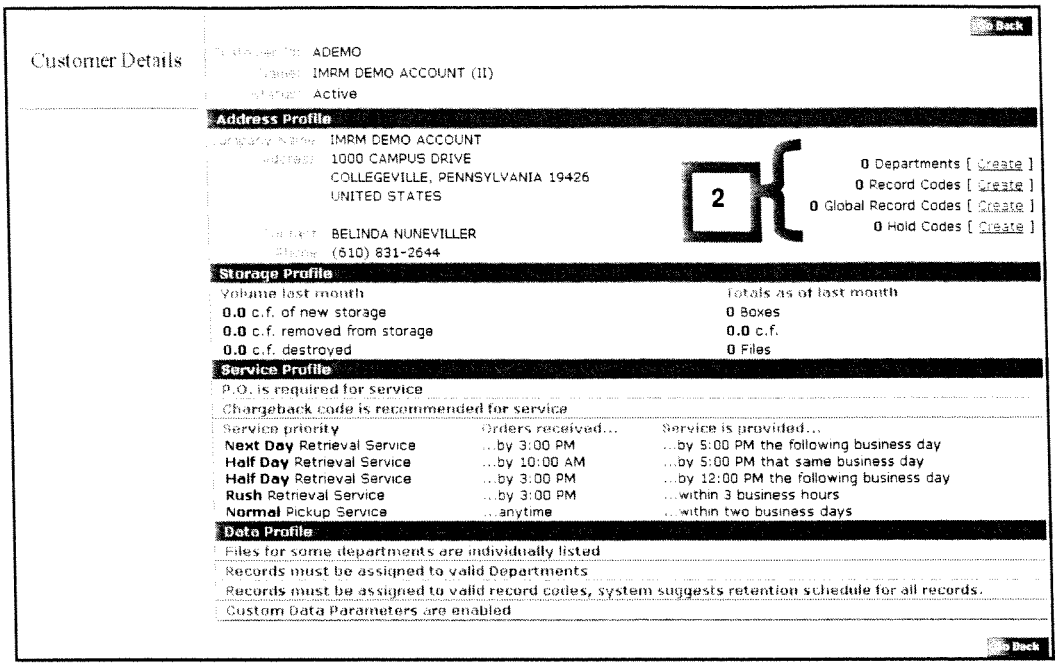
Account Profile

On Customer Details pages, administrators can view address and contact information, monthly storage volume, service priorities, data requirements, and other customer information.

Administrators can also view the divisions, departments, record codes, and hold codes associated with the customer.

1. Click on the Administration menu and select Account Profile

The Account Profile screen will display.



2. On Customer Details pages, you can do the following:

To...	Click...
View divisions	Divisions
View departments	Departments
View or create global record codes	Global Record Codes or Create
View or create hold codes	Hold Codes or Create
Return to the Record Center Customers page	Go Back

Storage Profiles	
Volume last month	Totals as of last month
Cubic feet (c.f.) of new items received for storage during the previous month	Total quantity of boxes in storage on the last day of the previous month
Cubic feet of items permanently withdrawn from storage during the previous month	Total cubic feet of items in storage on the last day of the previous month

Storage Profiles	
Cubic feet of stored items destroyed at the customer's request during the previous month	Total quantity of files in storage on the last day of the previous month. Does not include files that are unlisted, permanently withdrawn, or destroyed.

Service Profile		
Service Priority	**Orders received by...**	**Service provided by...**
Next Day Retrieval Service	3:00 p.m.	5:00 p.m. on the next business day
Half Day Retrieval Service	10:00 a.m.	5:00 p.m. on the same business day
	3:00 p.m.	12:00 p.m. (noon) on the next business day
Rush Retrieval Service	Before 3:00 p.m.	Within three (3) hours on the same business day
	After 3:00 p.m.	11:00 a.m. on the next business day
Normal Pickup Service	Any time	Within two business days

Data Profiles		
Data Issue	**Value**	**Explanation**
Are files individually listed?	Files are individually listed.	All departments of the customer individually list files in the same data format.
	Files are not individually listed.	No departments individually list files.
	Files for some departments are individually listed.	Some, but not all, departments individually list files in the same data format.

Data Profiles		
Data Issue	**Value**	**Explanation**
	Files for departments are listed under various file formats.	All departments individually list files, but in multiple data formats.
Is the box data keyed from the customer or Iron Mountain transmittal forms?	Box data keyed from Iron Mountain transmittals.	Box records are keyed from Iron Mountain transmittal forms.
	Box data keyed from customer transmittals.	Box records are keyed from customer transmittal forms.
Are valid departments required?	Records must be assigned to valid Departments.	Each new record must have a valid Department ID. If new records do not require valid departments, then this line is blank.
Are valid record codes required?	Records must be assigned valid Record Codes.	Each new record must have a valid Department Id. If new records do not require valid record codes, then this line is blank.

Iron Mountain Frequently Asked Questions

Frequently Asked Questions About the Iron Mountain Connect Record Center, powered by the SafeKeeperPLUS® system:

How do I get set up in the IM Connect Record Center?

Please call Systems Support at (800) 888-ASSIST to be guided through the process.

Do I need a separate account for the Record Center, or does my user ID for Iron Mountain Connect work for both?

You only need one login to access all Iron Mountain systems and applications. Contact your Account Manager or Iron Mountain directly to get your new Username and Password.

My login is not working. Who do I call to get activated?

Please call Systems Support at (800) 888-ASSIST for assistance.

How can I get additional help with the Record Center?

Online help is available within the Record Center. Animated tutorials are available on the Help page of IM Connect. For assistance via telephone, please call (800) 888-ASSIST.

How do I order empty cartons?

If the Record Center administrator at your location has granted you access to the order supplies privilege, you can place supply orders online through the Record Center. For assistance via telephone, please call Customer Response at (800) FAST-FILE.

Can I do my own transmittals online?

If the Record Center administrator at your location has granted you access to the Inventory Maintenance capabilities then you can do your own transmittals online.

When I do my transmittals online, how long will it take for the system to reflect the information?

The system will reflect the information when the corresponding cartons are scanned upon arrival at the Iron Mountain records center. This process takes approximately 24 - 48 hours.

I was in the middle of an order and I never checked out. What happens to those cartons?

The order will remain open until you either cancel or complete it.

Where does the information from the Instructions field appear on the Cart?

On the Cart page, the information entered in the Instructions text box will appear on the Outcard and Packing Slip.

How do unlisted files get listed after they are ordered?

When a user Requests an Unlisted File it becomes a temp file until the file is confirmed found. It then is listed in the Record Center (SafeKeeperPLUS) with the new Temp to Perm functionality. Once the temp file becomes a listed file, it can be reordered and will have all the properties of a listed file, including having the Checked out from Iron Mountain status if the file is out.

Is there a transportation option to allow a user to pick up a retrieval order?

The user should enter the information in the Special Instructions section when requesting a retrieval from the Record Center.

How do I edit boxes/files in the Record Center?

If users have the edit box/file privilege, they can search for a given box/file and click the Edit link on the search results page. If the user does not have the privilege the Edit link will not be viewable.

If a Record Code is selected using Lookup on the Add Box/File page, will it populate the destruction date and other fields required for Record Code data?

No. The information is calculated once the box is received. It is not populated on screen.

When will inventory entered via Add Box/File be searchable in the Record Center?

Inventory entered via Add Box/File will be available after Iron Mountain scans the record into the SafeKeeperPLUS system.

User enters data using Add Box/File.

User requests a pickup order.

Iron Mountain scans into the system and matches actual record to paperwork or metadata.

User can then order items via Quick Order entry, but it takes approximately 24 - 48 hours from receipt of the item by Iron Mountain before the records are searchable.

When do I use the Lock/Unlock function available under Add Box/File?

If you are entering multiple records that have identical values in one or more fields, use the Lock command for faster data entry. Once a field is locked, you do not need to re-enter its data in subsequent new records. To remove the lock, click Unlock.

Can the destruction date be edited or added to a box after the box has been inbound?

The destruction date will not be editable if the validate record code flag is set. If the flag is set, the destruction date will be calculated based on the retention information in the Record Center. If this flag is not set, the destruction date will be editable if the data entry parameters are set to allow entry of this field.

Iron Mountain Connect Contact Information

Our proven, structured processes provide security and accuracy in records storage and delivery 24 hours a day, 365 days a year. We're always available to take your call.

Support Contact Information:

Customer Service:

To discuss your unique business needs, call (800) FAST-FILE.

Technical Support:

For technical support needs, call (800) 888-ASSIST.

General Inquiries:

Not sure who to call? All general inquiries can be answered at (800) 899-IRON.

Visit Iron Mountain at: www.ironmountain.com

Glossary

Account Profile	Information about a customer, such as its divisions, departments, record codes, hold codes, and shipping addresses.
Accounting File	Data format for accounting records, with format-specific fields such as Client Name and Client Number.
Address Book	List of the addresses that a user can select for orders.
Administrator	User with access to all Record Center functions and the records for one or more customers, as well as the ability to manage user and account profiles.
Advanced Search	Filtered inquiry function that finds records by customer, record status, and other field criteria. See also: Basic Search.
Attention To Address	Location and contact where and to whom an item that has been retrieved from storage should be forwarded after delivery.
Audit Hold	Halts the destruction of an item pending review by an accounting firm or authorized governmental agency.
Basic Search	Full-text inquiry function that finds records by search words and numbers. See also: Advanced Search.
Bill Code	Classification that specifies how storage, service, supply, and other transactions and their charges are billed on customer invoices.
Billing Address	Location to which Iron Mountain invoices are sent for a particular customer, division, or department.
Box Department	Department associated with a box or the box in which a file or other item is stored.
Box Division	Division associated with a box or the box in which a file or other item is stored.
Box History	Chronological list of the orders and other transactions related to a box record.
Box Record	Set of data fields describing the customer, contents, transactions, and other information pertaining to a box.
Box Record Code	Record code associated with a box or the box in which a file or other item is stored. See also: record code.
Carrier Option	Order option that specifies how items will be transported (for example, by Iron Mountain or by a third-party courier).
Cart	List of records that you are planning to order from storage.
Chargeback Code	Customer-defined classification for tracking and allocating shipping and other charges to customers, contacts, and external projects.
Checkout	Function you use to submit retrieval and permanent withdrawal orders.

Criteria Field	Record field that can be selected in an advanced search.
Customer Box Number	Customer-defined, alphanumeric identifier for a box record. See also: SKP Box Number.
Customer File Number	Customer-defined, alphanumeric identifier for a file record. See also: SKP File Number.
Customer ID	Iron Mountain's unique alphanumeric identifier for a customer.
Customer Number	See: Customer ID.
Data Parameters	Settings that specify the key identifier, enabled fields, and required fields in a data format.
Data Profile	Summary of the data requirements for records assigned to a customer.
Department	An organizational unit of a division to which records of stored items can be assigned.
Destruction Date	Date when a stored item is scheduled to be destroyed, based on its record code or other retention instructions. See also: record code.
Destruction Date Calculation	Method of computing the date on which a stored item is to be destroyed. See also: record code.
Destruction Indicator	Code specifying the reason the destruction of an item has been put on hold (for example, Legal Hold).
Destruction Order	Customer request for a stored item to be destroyed by Iron Mountain. See also: destruction date.
Destruction Type	Code indicating how a stored item is to be destroyed at the expiration of retention.
District	Metropolitan area or region that serves as an Iron Mountain operational unit.
Division	An organizational unit of a customer to which records of stored items are assigned. A division contains one or more departments.
Email Confirmation Address	Address to which an email acknowledgement is sent when an order is received by Iron Mountain.
Event Date	Date of any customer-specified event in a box record (for example, when a file was first stored in the box).
Field Criteria	Record fields and values selected in an advanced search.
File	Document, image, or other item, usually stored in a box, which can have a unique file record.
File Group	A sequence or section of Open Shelf files.
File History	Chronological list of the orders and other transactions related to a file record.

File ID	Unique user-created identifier for an Open Shelf file.
File Record	Set of data describing the customer, contents, transactions, and other information pertaining to a file.
File Sequence Number	Number that specifies the position of a file in a box (for example, "1" for the first file).
Filters	Settings that restrict Advanced Searches to selected customers, departments, record codes, and record types.
Find In Field	Single, user-selected field that is searched by Quick Order Entry.
General Preferences	Settings that specify the default search method and delivery method for your Record Center sessions.
Global Record Code	Record code that applies to the records of all divisions and departments of a customer. See also: record code.
Hold Code	Customer-created code that blocks the destruction of the boxes to which it is assigned.
Image Request	Order to retrieve an image from storage at Iron Mountain and deliver it to a customer.
IMRM Retention	Length of time a record is to be kept in storage at Iron Mountain.
Individual List Codes	Setting specifying how file records are created for the individual files in boxes assigned to a department.
Individually Listed File	File that has its own file record.
Insurance 1 File	Data format for records of insurance claims and policies, with format-specific fields such as Office and Expiration Year.
Insurance 2 File	Data format for insurance claimant records, with format-specific fields such as Claimant Name and Loss Date.
Invoice Inquiry	Search function that finds the totals and component charges of invoices by date, division, and department.
Invoice Number	Alphanumeric identifier assigned by Iron Mountain to a customer invoice.
IOD	Image on Demand. See also: image request.
Key Identifier	Field that records are listed by in search results, your Cart, and other pages.
Law File	Data format for legal records, with format-specific fields such as Client Name and Matter Number.
Legal Hold	Halts the destruction of an item pending the outcome of litigation, government review, or other legal action.

Loan File	Data format for loan records, with format-specific fields such as Loan Number and Borrower Name.
Location	Iron Mountain district (region) where an item is stored.
Lock	Data entry command that saves the value entered in a field for use in subsequent records.
Long Description	Description of up to 2,500 words of the contents of a box.
Master Department	Default department created for every division.
Master Division	Default division created for every customer.
Medical File	Data format for medical records, with format-specific fields such as Patient Number and Entry Year.
Menu Bar	Graphic containing the Record Center main menu command (for example, Search and Orders).
Office Retention	Length of time a record is to be kept by a customer before it is sent to storage at Iron Mountain.
Offsite Shredding	Destruction process in which items are shredded at an Iron Mountain facility.
On Hold	Indicates that the boxes of a customer or department should not be destroyed.
Onsite Shredding	Destruction process in which items are shredded in an Iron Mountain mobile shredding unit at a customer location, so their destruction can be witnessed by the customer.
Open Shelf	System for storing unboxed files at Iron Mountain.
Order History	Chronological list of the transactions related to an order. Appears on the Order Details page.
Order Inquiry	Search function that finds the history, status, and other information about orders.
Order Line	Line on an order specifying the type, quantity, and other instructions related to a box, file, or other item.
Order Number	Number, generated by Iron Mountain, which uniquely identifies each service request pertaining to a record.
Order Status	Current disposition of a customer request.
Order Type	Specifies the kind of service requested from Iron Mountain.
Organization	Hierarchy of divisions and departments of a customer, pertaining to record keeping.
Overage	Charge for transporting items in an order in excess of the amount agreed to in the base charges.

Packing Slip	Form listing the information needed to ship a confirmed order (for example, customer name and address, items shipped, and order type).
Parameter History	Chronological list of the changes made to a data format.
Permanent Withdrawal Order	Request to permanently remove one or more records from storage.
Pickup Address	Location and contact person from which items will be transported to an Iron Mountain storage facility.
Pickup Order	Request for one or more items to be sent to an Iron Mountain storage facility.
Priority	Service level that specifies when an order will be picked up or delivered (for example, Next Day or Rush).
Privilege	User profile setting that grants a user access to a function, such as searching for records.
Qualifiers	Advance Search settings that specify how field criteria are searched (for example, Equal To or Contains). See also: field criteria.
Query	Words, numbers, and other sequences of characters entered in a search field.
Quick Order Entry	Rapid order command that lets you find and add records to your Cart in one step.
Rate Schedule	List of rates charged to customers for various types of transactions (for example, standard and exception rate schedules).
Receipt Date	When an item was originally picked up from a customer by Iron Mountain.
Recently Added Record	Box or file record that documents a box or file not yet processed for storage by Iron Mountain.
Record	Set of data documenting a box, file, image, or other item stored Iron Mountain. On Record Center pages, each record is listed by its key identifier.
Record Code	Customer-created code specifying the length of time that items are to be stored. Formerly known as retention codes.
Record Status	Current disposition of the item documented by a record (for example, At Iron Mountain or Destroyed).
Record Type	General category of records (for example, box records or file records).
Refile	Return a previously retrieved item to storage at Iron Mountain.
Report Center	Section of Iron Mountain Connect that enables you to request and view reports about Record Center activity, retention, and other topics.
Request Date	When an order was originally submitted to Iron Mountain.
Requested By User	Person who requested an order to Iron Mountain.

Requested For User	Person for whom an item was ordered.
Retention	Length of time, defined by a record code, that an item is to be maintained by a customer and by Iron Mountain.
Retention Hold	Assigns one or more hold codes to a box, department, or record code.
Retention Profile	Summary of the settings that determine the destruction date specified by a record code.
Retention Schedule	Classification specifying the type of time period (for example, Monthly, Yearly, and Indefinite) used to calculate the total retention of a record.
Retrieval Order	Request for one or more records to be temporarily removed from storage.
Search Criteria	Data fields that can be selected in an advanced search. Also known as field criteria.
Search Operators	Special words and characters that modify your queries in basic searches and searches within results. For example, a comma between search words operates as an "or."
Search Preferences	Settings that limit your searches to selected organizations, record types, record statuses, and other criteria.
Search Within Results	Search of the records found by a previous search, used to narrow your results.
Service Priority	Date and time when items are scheduled to be delivered at or picked up from the shipping address on an order.
Service Profile	Summary of the service priorities that can be selected on orders to or from a customer.
Ship-To Code	Classification that specifies where orders are to be shipped for a department.
SKP Box Number	SafeKeeperPLUS Box Number. A bar code number, provided by Iron Mountain, that uniquely identifies a box.
SKP File ID	SafeKeeperPLUS File ID. Unique identifier of a boxed file, consisting of an SKP Box Number plus a File Sequence Number.
SKP File Number	SafeKeeperPLUS File Number. A bar-coded identifier, provided by Iron Mountain, for a file record.
Sort Sequence	Order in which Open Shelf files are stored, based on their File IDs.
Standard File	General data format for file records, including four File Description fields suitable for most types of data.
Standard User	Person with non-administrative access to selected Record Center functions and customer records.

Storage Profile	Summary of storage statistics for a customer, division, or department.
Supply Code	Unique identifier for a type of storage supplies available from Iron Mountain.
Temporary File	See: unlisted file.
Total Retention	Length of time a record is to be kept in storage, both by the customer and at Iron Mountain (office retention plus IMRM retention).
Transmittal Form	Document used for pickup and retrieval orders that contains essential information about a box record such as the Customer ID, SKP Box Number, and Customer Box Number.
Unit Measurement	Incremental number of items associated with a supply code. For example, boxes must be ordered in packs of 25.
Unlisted File	File that is not individually listed in the box in which it is stored because it does not have its own file record. Formerly known as a temporary file.
User History	Chronological list of the changes made to a user profile.
User Profile	Set of functional privileges and organizations assigned to a Record Center user.
Valid Department	Approved, pre-existing department to which a customer's records can be assigned.
Vault	Fire-rated storage facility for magnetic media, with controlled temperature and humidity levels.
Volume Number	Identifier for a quantity of related customer files (for example, various files of a single patient).
Wildcard	Search operator indicated by an asterisk (*) at the end of a word that can stand for any sequence of characters.

timeanddate.com

Calendar for year 2009 (United States)

January

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
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February

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April

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September

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October

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November

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29	30					

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December

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20	21	22	23	24	25	26
27	28	29	30	31		

○: 2 ◑: 9 ●: 16 ◐: 24 ○: 31

Jan 1	New Year's Day
Jan 19	Martin Luther King Day
Feb 14	Valentine's Day
Feb 16	Presidents' Day
Apr 12	Easter Sunday
May 10	Mother's Day
May 25	Memorial Day
Jun 21	Father's Day
Jul 3	'Independence Day' observed
Jul 4	Independence Day
Sep 7	Labor Day
Oct 12	Columbus Day
Oct 31	Halloween
Nov 11	Veterans Day
Nov 26	Thanksgiving Day
Dec 24	Christmas Eve
Dec 25	Christmas Day
Dec 31	New Year's Eve

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These schedules list records common to many municipalities.

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M11 - Library Records (02/2005)	96.56 KB
M12 - Health Departments/Districts/Clinics Records (02/2005)	89.19 KB
M13 - Human Services/Social Services/General Assistance Records (02/2005)	37.7 KB
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M16 - Electronic Data Processing Records (02/2005)	88.97 KB

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Enter your issues with, comments on, or suggestions for the new website.

*Your email address: **

Please enter your email so that we can get back to you about your comments/concerns.

CAPTCHA

This question is for testing whether you are a human visitor and to prevent automated spam submissions.

*Math question: **

2 + 13 =

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enter the result. E.g. for 1+3, enter 4.

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ISOClaimSearch®

Medicare Secondary Payer Reporting Service

User Guide

Version 3.6

February 2012

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INTRODUCTION

ISO has developed the ISO ClaimSearch® Medicare Secondary Payer Reporting Service to help insurers comply with mandatory claim reporting requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173). The legislation requires reporting of bodily injury claims filed by Medicare-eligible claimants to the U.S. Department of Health and Human Services Center for Medicare & Medicaid Services (CMS). Failure to report carries a $1,000.00 per diem, per beneficiary civil penalty.

ISO ClaimSearch, in coordination with insurers and the insurance trade associations, worked with CMS to design a comprehensive Medicare Secondary Payer Reporting Service. The service will report Medicare-eligible claimants to CMS on behalf of ISO ClaimSearch participating companies in conformance with the legislation. By reporting through ISO ClaimSearch, companies will realize significant savings and workflow process efficiencies.

About This User Guide

This user guide has been created as a resource for customers who have chosen ISO as their reporting agent for Medicare Section 111 reporting. It will guide the implementation of changes to existing processes. It is not practical for this user guide to encompass all information for reporting since much of the Medicare Section 111 reporting is based on existing ISO ClaimSearch processes. We have included as much information in this manual as we felt was practical and have provided a section in this manual listing other AVAILABLE RESOURCES.

This manual has been created based on requirements provided in the CMS MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Worker's Compensation User Guide Version 3.3 published on December 16, 2011 as well as recent alerts posted by CMS. ***Information published in this guide may be updated subject to future CMS changes.***

This user guide is not meant to replace the CMS MMSEA Section 111 User Guide. Companies must be familiar with the CMS reporting requirements and regulations.

The information contained in this publication was obtained from sources believed to be reliable. ISO Services, Inc., its companies and employees make no guarantee of results and assume no liability in connection with your use of the information or the timeliness, accuracy or completeness of the information herein contained.

Summary of Changes

In this version of the ISO ClaimSearch Medicare Secondary Payer Reporting Service User Guide 3.6, the following changes have been made since version 3.5.

- Page 24 – A statement was added for system-to-system companies to indicate which ICD9 codes are sent to CMS if they are reported on both the UC01 and UEX3 records.
- Page 31 – Two new warnings were added. Warning 71 – No fault limit exceeds $99,999,999.99; Warning 72 – Total of TPOC amounts exceed $99,999,999.99.
- Page 32 – SSN is no longer handled as a key field change per CMS' new requirements.
- Page 36 – a new grid was added to outline the new dates and threshold amounts for liability TPOC reporting.
- Page 39 – a statement was added to indicate that the claimant name must match (in addition to other key fields) on claims which are converted from legacy to Universal Format.
- Page 45 – additional error codes SP32, SP50, TN99 were added. Compliance codes 02, 04-09 were marked as obsolete as of October 2011.
- Pages 45-46 – TIN Reference Response File section was added to explain the process for the new TIN response files posted by CMS as of October 2011.
- Page 49 – the screen-shot for the Quarterly Report Statistics has been replaced. The stats for files sent and files received now appear on separate screens with a drop-down to choose files sent or files received from CMS.
- Page 118 – additional error codes SP47, SP50 and TN99 were added.
- The filler in the query response, acknowledgement and error file header and trailer records have been updated to equal 600 bytes.
- The Reported Source on the query response file has been updated to include additional sources. Additional legacy sources include A – ACE software, D – paper (data entry), I – IIN, O – Online, T – tape, X – tracs, 3 – 3780.

The following changes have been made since version 3.5

- A new lawyer service provider role (page 20) has been added to be used specifically for reporting a lawyer representative to CMS.

  Currently, ISO allows reporting of multiple lawyer service providers on one claim. CMS accepts only one lawyer representative in reports. If more than one lawyer is entered in the claim report, ISO chooses the first lawyer record found on the system that contains all of the data fields required by CMS (name, address and phone number) and uses that lawyer record in the quarterly claim file for CMS. Using this method to choose the lawyer to report when more than one is entered can result in sending to CMS a lawyer who may not be handling the claim or may not be the primary representative.

In order to control exactly which lawyer is sent to CMS, ISO ClaimSearch has added a new "LS" (Lawyer for CMS Claimant) role to be used for either claimants or additional claimants. When this role is used in a report, it will indicate the lawyer to be reported to CMS, even when there are other lawyers included on the claim. If any of the CMS-required data fields are missing for this role, you will receive a warning message on your ISO ClaimSearch match report indicating the missing fields. If you do not add the missing fields, the claim will be rejected when sent to CMS.

You must use the LS role if you report multiple lawyers and want to control which one is sent to CMS. If you do not use the new LS role, ISO ClaimSearch will continue to send the first lawyer found on the system with all of the required fields. If you use the LS role for multiple lawyers on one claim, the first one reported will be sent to CMS.

- Additional warnings have been added at the request of our participants to address some of the more common reasons for CMS rejections. See page 30.

  New warnings include:

  45 – 48 TPOC dates 2- 5 must be greater than the CMS Date of Incident

  49 Total of all TPOC amounts is below the dollar threshold

  50 – 68 ICD9 codes 1 – 19 are invalid

  69 TPOC coverage has ORM indicator = Y. Change to N. If needed add ORM coverage/loss with ORM = Y.

  70 ORM claim was entered with ORM = N. Claim will not be sent to CMS until ORM = Y or until TPOC date is entered.

  Other warning changes include:

  Warning 22 & 43 have been removed.

  Warning 21 is re-worded and will only be generated if the ICD9 Diagnosis Code is Missing (new warnings will alert you if the ICD9 is invalid).

  Warning 44 is re-worded to indicate that the TPOC Date 1 must be greater than the CMS Date of Incident (new warnings were created for TPOC Dates 2 – 5).

- HICN is no longer considered a key field change. Description of Illness or Injury is no longer considered an update field (page 33).

- Page 32 was updated to explain new reasons for delete transactions: For claims already accepted by CMS, if you report the "Do not send to CMS" indicator at either the claimant or coverage level, if you remove the Medicare eligible indicator, if you change the coverage to a non-CMS reportable type, or if the claim is voided from the ISO ClaimSearch database, ISO will send a "delete" record (Action Type "1") to CMS.

- The reference to the ORM termination date needing to be more than 30 days greater than the date of incident has been removed due to a change in CMS requirements (page 35).

- ISO now will alert you via a warning message if your TPOC claim is below the dollar threshold (page 36).

- Additional information has been provided as to the reason for many claims receiving Disposition 49.

- Additional compliance codes have been added (page 45). ***Compliance Codes 04 through 09***

  These compliance codes are sent when invalid TIN/Office Code Addresses are sent on the TIN Reference Field Detail Record. Codes are provided for invalid Mailing Address Line 1 (Code 04), invalid Mailing Address Line 2 (Code 05), Invalid City (Code 06), Invalid State (Code 07), Invalid Zip Code (08) and Invalid Foreign Address (Code 09). See the CMS ALERT: TIN Reference File Address Validation Information dated November 18, 2010 for more information.

- The Resources section has been updated.

- At the request of customers who need additional information on the result files to match claims back to their system, additional fields have been added to the Query Response, and Claim Acknowledgment and Error files. The following fields were added to the Query Response file: ISO File Number, Policy Number, Date of Loss, Adjuster Name (if more than one adjuster appears on the claim, the first adjuster will be provided), Insured Name, Submitted Claimant Last Name, Submitted Claimant First Name, Claimant Middle Name, Routing/Miscellaneous Info, Claim Source (legacy or Universal Format), and Reported Source (FTP, XML, MQ or Web). If using the text file, the size of the file is now 600 bytes, so you may need to adjust your programming to account for the larger response file. See Appendix C. The following fields were added to the Acknowledgement and Rejection files: ISO File Number, Policy Number, Date of Loss, Adjuster Name (if more than one adjuster appears on the claim, the first adjuster will be provided), Insured Name, and Routing/Miscellaneous Info. If using the text file, the size of the file is now 600 bytes, so you may need to adjust your programming to account for the larger response files. See Appendix D & E.

- Page 159 – a note was added to alert you to the potential problems of choosing default or generic ICD9 codes.

SERVICE OVERVIEW

The ISO ClaimSearch Medicare Secondary Payer Reporting Service will help insurers comply with mandatory claim reporting requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. The legislation, effective July 1, 2009, could affect every bodily injury settlement that involves an insurance carrier or self insurer and a Medicare-eligible claimant/plaintiff.

Section 111 of the act adds new mandatory reporting requirements for all responsible reporting entities (RRE), group health plan arrangements, property casualty and workers' compensation insurers, and self-insureds. The legislation requires reporting of bodily injury claims filed by Medicare-eligible claimants to the U.S. Department of Health and Human Services Center for Medicare & Medicaid Services (CMS).

CMS has added more than 100 distinct fields of data that you must report. Reporting will occur as follows:

- Quarterly, ongoing – all no-fault insurance and non-contested workers' compensation claims
- Single instance – all contested cases resulting in "a single settlement, judgment, award or other payment"

The service includes a Medicare-eligibility query function, data collection and screening, automated claim file submissions, and processes for handling CMS acknowledgement and rejection notices.

The ClaimSearch Medicare Secondary Payer Reporting Service solution is integrated with the existing ISO ClaimSearch claim-reporting process. To participate, your company must use the ISO ClaimSearch Universal Format reporting specifications and report additional data elements to ISO ClaimSearch. The addition of the new elements required by CMS should require only minimal programming changes for customers using system-to-system communications.

ISO ClaimSearch offers a web reporting option for companies that are unable to capture the additional fields in their systems or who do not have the necessary programming resources. Companies will be able to update previously reported claims with the additional CMS-required information through the ISO ClaimSearch web interface.

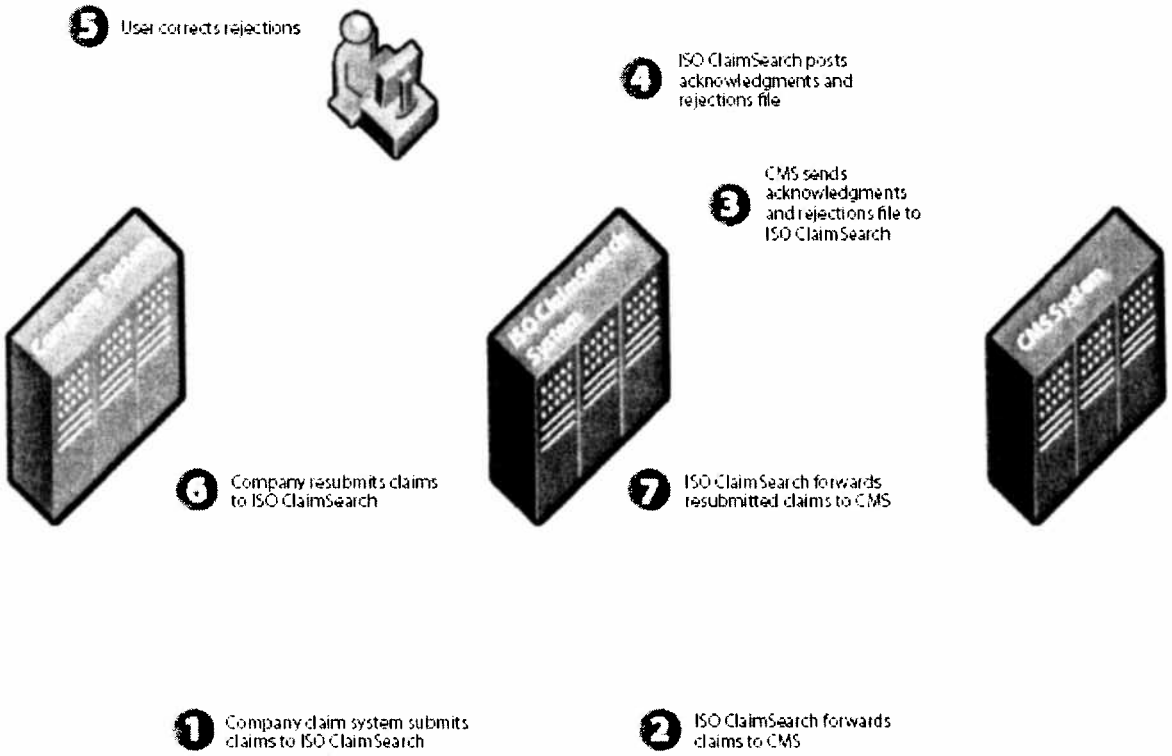
The ISO ClaimSearch Medicare Secondary Payer Reporting Service offers:

- Timely quarterly reporting to CMS
- Help in identifying Medicare-eligible individuals through a monthly query function
- A process for notifying customers of the claims CMS rejects
- A process for correcting CMS rejections
- Timely warnings when claims with Medicare-eligible claimants are missing CMS-required fields
- An optional pre-query extract process to identify claims already reported to ISO ClaimSearch and assist in the monthly query process
- Management reports to assist with compliance

Choosing ISO as your CMS reporting agent helps you to:

- save internal programming costs
- streamline workflow (as you are already reporting this data to ISO ClaimSearch)
- comply with the CMS regulations
- obtain Social Security numbers (SSN) and other public-records information you may need through our optional Append-DS service

The ISO ClaimSearch Medicare Secondary Reporting Service Workflow



TIMELINES

Registration with CMS (May 1, 2009 - On-Going)

Companies must register their data-reporting method with CMS for each responsible reporting entity (RRE). CMS will assign a quarterly reporting period to each RRE at registration. Registration remains open past this date if a new company needs to register a new responsible reporting entity (RRE) or an existing RRE, to request more RRE codes.

Registration with ISO (Current/On-Going)

In addition to registering with CMS, ISO ClaimSearch participants choosing to use ISO as the reporting agent must sign an ISO Product Supplement and complete Authorization Forms.

Query Process (In Production)

ISO is submitting production query files to CMS on behalf of customers who have completed the ISO registration mentioned above and have requested the optional query service. Customers may use the results of the production queries to begin updating claims. If your RRE has not yet had a query performed and you are unsure why, please contact us at claimsearchmsp@iso.com.

Pre-Query Extract (Current/On-Going)

For a nominal fee, Companies may request from ISO a pre-query extract of claims currently in the ISO ClaimSearch database to determine which additional claims must be reported, which claims must be converted to Universal Format, or which claims must be updated with additional data elements.

Testing Universal Format Changes with ISO (Current/On-Going)

Companies that report via a system-to-system interface and have completed the Registration with ISO mentioned above may test any programming changes to their Universal Format interface through their designated ISO Testing Representative. Once testing is complete, customers may begin entering the information in the production environment. Companies reporting via the web do not need to test; the new fields are available in production now.

Testing Files with CMS (Complete)

ISO completed "pilot testing" with the Coordination of Benefits Contractor (COBC). By completing the pilot, the COBC will automatically move the RREs from Testing Status to Production Status. If the status of your RRE still shows as "Testing", please contact your EDI representative and ask to be switched to "Production" status. There is no further testing an RRE is required to perform in order to be in Production Status.

Production (Current/On-Going)

Companies are required by CMS to submit production files based on the pre-determined quarterly reporting schedule. As of 1/1/11, ISO is now sending production quarterly claim files to CMS based on each RRE's assigned reporting period.

REGISTRATION OVERVIEW

Registration for reporting of injury claims to the Department of Health and Human Services Center for Medicare and Medicaid Services (CMS), in compliance with the mandatory claim reporting requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173), began on May 1, 2009 and will remain open for companies that are new or that must register a new RRE. Prior to registration, companies planning to use ISO ClaimSearch to report their Medicare-eligible claimants will need to be familiar with the registration process.

We appreciate your consideration of ISO ClaimSearch as your reporting agency for CMS reporting. You can send all applicable claims to ISO ClaimSearch for reporting to CMS, if you report using the ISO ClaimSearch Universal Format by system-to-system reporting or via the ISO ClaimSearch website. The instructions below will help you register with CMS if you plan to use ISO ClaimSearch as your reporting agency.

Registering With CMS

The registration for CMS reporting is accessible via the Coordination of Benefits website at www.Section111.cms.hhs.gov. The registration process involves five steps:

- Identify an Account Representative, Account Manager and Account Designees
- Determine reporting structure
- Register the new Responsible Reporting Entity (RRE) on the CMS website
- RRE account set up on the CMS website
- Return signed Profile report

The CMS Registration for Medicare Secondary Payer, Section 111 Reporting requires the information specified for each RRE. Required information is:

- Name and address of the entity (insurer or self insurer)
- Tax ID number
- NAIC code (if an insurer)
- Optional subsidiary information

STEP 1 - Identification of an Authorized Representative

This is a senior manager who is authorized to enter into an agreement (must sign Profile Report and Data Use Agreement).

- Authorized Representative will designate an Account Manager.
- The Authorized Representative will receive e-mail correspondence and compliance information from CMS.
- The Authorized Representative will receive the PIN and RRE ID which is to be used to register to report to CMS.
- The Authorized Representative must annually confirm that the current profile report is correct.

- **Identification of the Account Manager (one per RRE)**
  - Registers on the Coordination of Benefits Contractor Website (COBSW) to obtain a Login ID and password.
  - Responds to questions on the registration form.
  - Can appoint other entities as Account Designees.
    NOTE: The most appropriate status for ISO ClaimSearch under the company (RRE) is as an Account Designee; ISO should not be chosen as the Account Manager.

- **Identifying the Agent and Account Designees (ISO ClaimSearch)**
  - The Account Manager will provide Agent information to CMS as part of the registration process (*indicating ISO ClaimSearch as an Agent for CMS reporting*).

Agents can be designated as Account Designees.

This is the preferred status for ISO ClaimSearch.

As an Account Designee, ISO ClaimSearch will be able to upload and download company files to and from CMS. Account Designees are also authorized to review file processing status and statistics. ***NOTE:*** *Some RREs who have already registered ISO as the agent did not choose the five ISO representatives as Account Designees. This is an important step because ISO will not be able to transmit files without this designee status. If you have already registered, please make sure you chose the five ISO representatives as Account Designees.*

Once the online registration is completed, CMS will send a profile report that includes the RRE ID, your production Live Date, and the ongoing quarterly reporting period.

STEP 2 - Determine Reporting Structure

Only one file per RRE can be reported during the assigned quarterly reporting period. If there is a need to report more than one file per RRE per quarter, CMS recommends that a second RRE code be obtained.

STEP 3 - New RRE Registration

In this step, a company representative (does not need to be the Account Representative) will select New Registration on the CMS website and enter the registration information above. CMS will validate the information, and will send notification *to the Authorized Representative* with a PIN and RRE code. The Authorized Representative will give the codes to the Account Manager, who will complete the registration via the CMS website.

STEP 4 - RRE Account Set Up on the COBSW (CMS) website

The Account Manager must complete this online.

- Use the PIN and RRE ID sent by CMS to the Account Representative
- Access the Account Setup button on the COBSW (CMS) website at www.Section111.cms.hhs.gov.

It is during this process that the information on ISO ClaimSearch as a reporting agent is entered.

Important: *You will need the following information to register ISO as your Agent.*

- Name: ISO Services, Inc.
- Address: 545 Washington Blvd. Jersey City, NJ 07310
- Contact e-mail: Claimsearchmsp@iso.com
- TIN: 133973142
  ***When entering the TIN, please do not include dashes or spaces.

Each RRE must select a file transmission method. If ISO is your agent, indicate the transmission method of SFTP.

After the Account Manager successfully receives a COBSW (CMS) Login ID, he/ she can invite an Account Designee to register for Login IDs. Only one Login ID is allowed per user.

- When adding a Designee, the name and email address of the Account Designee must be an individual; company names are not allowed.

Please enter *all four* ISO ClaimSearch contacts below as Account Designees:

- John A. Giknis: jgiknis@iso.com
- Lynn M. Roberts: lmroberts@iso.com
- Bryan Berkowitz: bberkowitz@iso.com
- Marilyn Orthouse: morthouse@iso.com

In addition to the four designees above, please include ***one*** additional designee based on the reporting group to which you were assigned. For example, if you were assigned to Group 5, choose the four designees listed above plus the additional one for mspreporting5@iso.com.

NOTE: CMS has automatically added the appropriate designee below to many existing accounts, but if they did not add it to your RRE's account, please do so. Adding the additional designee will assist ISO in transmitting files and investigating issues.

Group 1 -	mspreporting1@iso.com	Group 7 -	mspreporting7@iso.com
Group 2 -	mspreporting2@iso.com	Group 8 -	mspreporting8@iso.com
Group 3 -	mspreporting3@iso.com	Group 9 -	mspreporting9@iso.com
Group 4 -	mspreporting4@iso.com	Group 10 -	mspreporting10@iso.com
Group 5 -	mspreporting5@iso.com	Group 11 -	mspreporting11@iso.com
Group 6 -	mspreporting6@iso.com	Group 12 -	mspreporting12@iso.com

The Authorized Representative will receive a profile report via email from CMS, once the account set up has been completed on the COBSW. It will include:

- Registration summary information
- Data file transmission information (This will include ISO transmission information, as agent)
- The RRE ID for all reports
- The assigned production live date and ongoing quarterly submission timeframes
- Contact EDI representative

STEP 5 - The Authorized representative is to sign the Profile report and return it to the Coordination of Benefits contractor.

*****NOTE: Your RRE will remain in Set-Up status until the profile report is returned at which time your status will be changed to Testing or Production status.**

Deciding How Many RREs Your Company Needs

An RRE is required for the submitting of claims to CMS and the receiving of acknowledgements and rejections from CMS. Acknowledgements and rejections are posted in the Account Management section of the ISO ClaimSearch web site. Each RRE will require a separate registration with CMS and will receive a unique RRE Code, Reporting Period and EDI Representative.

Companies may register one or more responsible reporting entities (RREs). If a company can report to ISO ClaimSearch in one transmission, we recommend that the company establish one RRE at the group or company level to keep reporting simplified. The more RREs that a company chooses, the more complex the reporting process will be. However, companies may consider using separate RRE codes if:

- The company reports claims to ISO ClaimSearch under a separate reporting code
- The company needs ISO to separate data submitted to CMS
    - By line of business or business unit
    - By geographic region (for example, Northeast, Midwest, West)
    - For organizational requirements (for example, if a company wants separate reporting for a group or office level)
- The company uses third-party administrators and is required to segregate results
- Some of the claims involve self-insurance, requiring separate registration by the self insured

We recommend that companies be familiar with their ISO ClaimSearch participant profile and how the company is currently reporting to ISO ClaimSearch. Most companies report as a group, using one ISO ClaimSearch company code. Some groups have sub-groups, companies or business units that report separately to ISO ClaimSearch. For further clarification, check your company's Integrated Statistics Report in the Account Management section of the ISO ClaimSearch website for more details on how your company reports.

Other, generally smaller, single-company configurations report to ISO ClaimSearch on an individual company basis.

RRE Identification When Reporting Claims, Using the CMS Query Function and Reporting To CMS

For insurers or self-insured companies, if your company has more than one RRE which ISO cannot link to a specific company or office, you will need to identify the RRE code on each bodily injury claim reported to ISO ClaimSearch that will be queried or submitted to CMS. If your company only has one RRE code, TIN and Site ID for the company or an office, no further steps will be needed – identification of your RRE code will be automatic, as you will have been set up under that RRE code in ISO's membership system. Since TPA's report for multiple insurers or self-insureds, TPAs will always have to supply the RRE code on each claim to be queried or reported to CMS.

When using the CMS Query function you will also need to identify the RRE code for the query file to indicate to us which claimant is assigned to which RRE. A separate query file will need to be submitted for each RRE. If your company has only one RRE, the identification will be automatic.

The CMS registration process is flexible regarding the number of responsible reporting entity (RRE) codes a company can select. Companies can report in nearly all reporting configurations. It is important to note, however, that **each** RRE must complete the registration process individually. We will be happy to work with participating companies to review their reporting procedure.

Signing Up With ISO

Companies that wish to report to CMS through ISO ClaimSearch must contract and authorize ISO ClaimSearch to be their reporting agent. A Product Supplement and Authorization Form are required by ISO ClaimSearch in order for ISO ClaimSearch to submit data on the company's (RRE's) behalf. If the company has multiple RREs, only one Product Supplement is required; however, an Authorization Form must be completed for each RRE. The Authorization Form is where you will provide ISO with your RRE code(s), TIN(s), SITE ID(s), Reporting Period, Account Manager and other information necessary for reporting. See Appendix E for a sample Authorization Form and Instructions. Product Supplements and Authorization Forms can be obtained through claimsearch.sales@iso.com.

NOTE: *Completing this process with ISO is important. ISO will not be able to query your company's claims or report your company's claims to CMS until ISO ClaimSearch CMS registration is complete, even if you have already registered with CMS.*

For system-to-system companies who wish to test Universal Format programming changes for fields such as the Medicare-Eligible Indicator, RRE Code, TIN, SITE ID and to test receiving the CMS Missing Field Warning messages, companies must first be set up in ISO's membership database as CMS participants based on the information provided on the Authorization Forms.

For companies who wish to begin populating existing claims or to report new claims with fields required for CMS reporting, it is best to first participate in the ISO ClaimSearch CMS program. If your company will be using more than one RRE Code, TIN or SITE ID, each claim will need to include this information. You will not be able to include this information on your claims until you have been set up as an ISO ClaimSearch CMS participant.

NOTE: Third Party Administrators that are ISO ClaimSearch participants are authorized to participate in the ISO ClaimSearch Medicare Secondary Payer Program on behalf of their clients. It is necessary, however, that all insurers, self insurers, and self insured pools represented by a TPA be registered with CMS. CMS registration information (such as RRE codes, Account Manager's information and reporting periods) for companies that are not ISO ClaimSearch participants must be included in the Authorization Forms submitted to ISO by the TPA as part of the ISO ClaimSearch registration in the CMS program.

Third Party Administrators that report on behalf of companies that are ISO ClaimSearch participants, and have registered on their own for the ISO Medicare Secondary Payer program will need to report only the RRE code of those companies. Acknowledgement, Rejection and Query file results will be returned to the Account Management section of ISO ClaimSearch under the RRE code of the participating company filed on the submitted report.

Changes to Your Reporting Structure

Once you have signed up with ISO and have provided your RRE codes, TINs, SITE IDs and reporting period, it is important to keep ISO informed of any changes to your reporting structure. ISO can only query and report claims that can be identified by an RRE code. If you have added additional RRE codes, ISO must be notified in order for CMS reporting to occur. In addition, ISO will automatically build the TIN Reference File required by CMS based on the information you provided during registration with ISO. If any changes are needed to your TINs or SITE IDs, you must notify ISO in order for the proper information to be sent in your TIN Reference File.

Annual Review of the Profile Report

As of January 2012, CMS will e-mail the RRE's profile report to the Authorized representative annually, based on the receipt date of the last signed profile report. The RRE will be asked to confirm via e-mail to CMS that their current information is correct. Failure to confirm this information may result in deactivation of the RRE ID by CMS.

DETERMINING MEDICARE ELIGIBILITY (QUERY) OVERVIEW

To help companies identify Medicare-eligible claimants, every month ISO will provide an optional query of the CMS database for each participating RRE. Companies who have chosen ISO to be their agent may choose to have ISO always perform the query, or companies may choose to do the query themselves. Only one query file per month is allowed per RRE, so if you choose ISO to do the query for your company, you cannot also perform a query on your own.

Using the HEW software provided by CMS, the ISO ClaimSearch system will query your company's entire history of claims existing on the ISO ClaimSearch database which qualify for CMS reporting against the CMS database. For querying purposes, all claims must contain the claimant's name, SSN or HICN, date of birth and gender and must be associated with an RRE code.

ISO will post the positive results of the query to the Account Management section of the ISO ClaimSearch website so users can log in to check the Medicare eligibility of claimants. ISO will post the individuals who were positively identified as being Medicare recipients. The system will provide that information in a text file format as well as in a Microsoft Excel spreadsheet. Once Medicare eligibility has been determined, it is each company's responsibility to update the claims with the Medicare-eligible Indicator set to "yes" to indicate which claims ISO ClaimSearch should send to CMS.

Which Claims Qualify For The Query?

ISO will query a customer's entire inventory of Monoline Casualty "legacy format" and/or Universal Format claims currently on the database, as long as they meet the criteria for querying. Currently ISO has casualty claims on the database with received dates going back to 1992.

In order for a query to be performed, the claim must have a workers' comp, no-fault or liability coverage type. See Appendix A for valid CMS coverage types.

Only claims with the following required fields may be queried:

- Claimant Name (*since this is an ISO required field, it will always be present.*)
- Gender (*if the gender was not reported, ISO will pass "unknown" to CMS. Legacy casualty claims do not have a gender field. If you wish to add gender to a legacy casualty claim, you may do so using the Pre-Query Extract File process mentioned below.)*
- Date of Birth (DOB)
- Social Security Number (SSN) or Health Insurance Claim Number (HICN)
- RRE Code (if your group, company or office location has more than one RRE assigned or if your ISO ClaimSearch membership is a TPA).

If your company currently reports the status of the claim as "closed" with the closing date, any ORM claims which were closed *prior* to January 1, 2010 and any TPOC claim closed *prior* to October 1, 2011 will not be queried. If you do not report the status and closing date, ISO will assume the claim is still open and will perform the query. *(Legacy claims do not have a status or closing date field, so all qualifying legacy casualty claims will be queried unless you use the Pre-Query Extract File process mentioned below to indicate closed legacy claims).* Claims with closed dates *after* the threshold dates will continue to be queried.

Only claims that aren't already marked with the Medicare-eligible indicator set to "yes" will be queried. Once a claimant is marked as Medicare-eligible, ISO will no longer perform the query. The only way to stop the query is by marking the Medicare eligible indicator = "yes" or the Stop Query indicator, otherwise ISO will continue to query the claims each month.

Updating Existing Claims for the Query – Pre-Query Extract File Overview

Participants in ISO's Medicare Secondary Payer (MSP) Reporting Service must identify which pending claims previously submitted to ISO ClaimSearch must be reported to CMS to assure compliance with the requirement to report all injury claims filed by Medicare-eligible claimants.

As part of the MSP Reporting Service, ISO ClaimSearch will automatically query your submitted claims against the CMS Medicare Eligibility database each month to help you identify Medicare-eligible claimants.

In order to submit queries to its database, CMS requires certain fields of information on each claim: Claimant Name; SSN or HICN; Gender; and Date of Birth and RRE code (if more than one or if your ISO ClaimSearch membership is a TPA).

Since claims may have been reported to ISO ClaimSearch without some of the fields required for the CMS query, ISO will provide, upon request, an extract file of all of your company's injury claims contained in the ISO ClaimSearch database.

This full inventory of claims will allow you to identify:

1. Closed claims that do not need to be reported to CMS
2. Open claims that should be queried against the CMS database to find out if the claimant is a Medicare recipient
3. Claims missing data elements required by CMS for queries or reports
4. The format of the claim report submitted to ISO ClaimSearch – legacy or Universal Format. Both types can be queried with CMS, but only claims in Universal Format can be reported to CMS. You will need to convert all claims in legacy format with Medicare-eligible claimants to Universal Format for reporting to CMS.

Here is how the Pre-Query Extract process will work. The pre-query extract file will provide:

- Information helpful to ISO for internal purposes (ClaimSearch Identifier, Person Number, Run Type).
- Basic information regarding the claim (Company/Office Code, Claim Number, Policy Number, Date of Loss).
- Information regarding whether required fields for the query are present on the claim (Claimant Name (always present), Date of Birth, SSN, Gender (a gender of unknown will be sent to CMS if the gender is not provided).
- The Policy/Coverage/Loss Type will be shown, as well as an indicator to let you know if the type is CMS-Reportable.
- An Indicator showing if the claim was reported in the Legacy Format or Universal Format. Legacy claims can be queried, but must be converted to Universal Format if the person is a Medicare recipient and the claim needs to be reported to CMS.
- The claim status of Open or Closed (if reported), as well as the Closing Date (if reported). ISO ClaimSearch will not query any ORM (No-Fault or WC) claims that can be identified as being closed prior to 1/1/10, and will not query any TPOC (Liability) claims that can be identified as being closed prior to 10/1/11.

As part of this process, customers can update the file to include the necessary information and return it to ISO to allow the CMS query process to be performed. Note that customers that plan to report to CMS using multiple Responsible Reporting Entity (RRE) codes will also need to indicate the applicable RRE code for each claim.

ISO will charge a fee to extract this file, send it to you for review and updating, receive your updated file, and prepare it for the CMS query process. Please contact claimsearch.sales@iso.com to obtain pricing information and an authorization form to request the extract file.

Pre-Query Extract File Processing Details

The Pre-Query Extract File Process may serve multiple purposes for customers using ISO to perform the monthly query of claims/claimants against the CMS file to identify Medicare recipients.

1. It may be used only for informational purposes to see which claims are currently on the ISO ClaimSearch database, evaluate whether those claims are the appropriate types to be queried, and whether the data fields required for the query are available.

2. Some customers may not want to update individual claims with missing information simply for the query. The extract process would allow them to provide ISO with the necessary information to perform the query in a simple one-file process. *Please note that providing the information to ISO through this format will not update the actual claim on the database.* This process will allow ISO only to perform the query. If a claimant is found to be Medicare-eligible, the actual claim must also be updated with the necessary fields before being reported to CMS.

3. If a company has registered more than one RRE code for a group, company or office, each claim must be identified with the correct RRE in order for the query to be run. Providing the RRE code in the file that is returned to ISO will allow ISO to query the claims in the correct RRE file. If a company registers only one RRE, it is not necessary to provide the RRE code on each claim because ISO will be able to derive it from our membership system. However, TPAs must report the RRE code on each claim to be queried and/or reported to CMS even if they only have one RRE code assigned.

If the customer wishes to append the RRE code or any of the required fields for the query, or wants to supply the closing date in order to stop the query process, the customer can send the file back to ISO with the applied fields populated. The applied fields include: RRE Code, SSN, Date of Birth, Gender, Open/Closed Indicator and Closed Date.

NOTE: Providing information in this format will populate *only* the query table; it will not add the fields to the actual claim. If a claimant is identified through the query to be a Medicare recipient, any additional fields will need to be added by the customer to the actual claim, along with the Medicare- Eligible Indicator for reporting the claims to CMS.

In order for the query to be performed, *all* of the required fields for each claimant must be added *either* through this process *or* by updating the claim on the database. The query cannot be performed if some of the fields are added through this process and others are added directly to the claim. The query can only be performed if all of the fields are included in the claim record in the database, or if all of the fields are added through this process -- not using a combination of the two.

Two files will be created: one is a fixed-length text file and the other is an Excel file. The files contain identical information. If you wish to append the RRE code or any of the required fields for the query, or want to supply the closing date in order to stop the query process, you may send the file back to ISO with the applied fields populated. If you return the flat file (.txt), the new information should be included in positions 203-242 in the attached record layout. If you would like to send back the Excel spreadsheet, please include the applied information in columns A (RRE), O (date of birth), S (SSN), U (open/closed indicator) and W (closed date). Do not alter the file layout in any way; if there are any claims you do not need to update, you may remove the claim in its entirety when returning it to ISO ClaimSearch. Either the fixed length or the Excel file may be sent back to ISO with appropriate changes.

Please see Appendix G for the file layout which will identify the fields that will be provided to the customer, as well as the fields that the customer may apply to the file to update ISO's query tables. Extract files are available in a fixed width format or in a delimited file format.

Pre-Query Extract File Instructions

1. To request a Pre-Query Extract file, please complete an Authorization Form and return it to ISO following the instructions on the Form. If you have any questions or need to obtain an Authorization Form, please contact your ISO Account Manager or Account Executive at 1-800-888-4476 or send an e-mail to claimsearch.sales@iso.com.

2. When the file is ready, your company's technical contact as listed on the Pre-Query Extract Authorization Form will be notified via e-mail. The extract file will be placed in a secure FTP directory for you to retrieve. You will be provided with a URL, ID and Password to log in to download the file.

3. The first "history" extract will contain all claims on the database up to the point that the file is created.

4. Future extracts may be done based on a specific date range for an additional charge.

5. If you would like to add new information to the file and return it to ISO so that we can add it to the query table, place the file in the same FTP directory with a file name of "New Information." Send an e-mail to claimsearchdatabasedevelopment@iso.com to let us know that the file has been uploaded.

Results of Query File

ISO will send the monthly query files for each RRE to CMS on the first Sunday of each month. All claims to be included in the query must be entered into the ClaimSearch system by the day before the file is created on the first Sunday of the month. Once ISO sends the query file to CMS, it may take CMS up to 14 days to respond. When ISO receives the results from CMS, we will post the results to the Account Management section of the ISO ClaimSearch website so authorized users can log in to download a file containing the claimants which were positively identified as being Medicare recipients. Only users with access to this specific file will be able to log in. To obtain access for users, please complete the Authorization Forms provided in your ISO registration package. ISO will send an e-mail to the RRE's Account Manager informing them that the file has been posted.

Below is a screen shot of what the Account Management screen looks like:

ISO ClaimSearch CMS Reports

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For reports questions, please call 201-469-3159, or send an e-mail to cmsreports@iso.com

RRE Code: Report Type:

Query Reports

Date	Excel File	TEXT File	Download
9/16/09	QUERY_000012133_09162009._01.csv	QUERY_000012133_09162009._01.txt	Complete

Users with access to download files for multiple RREs will see a drop down where they may select the RRE code for the file they wish to download. There will be a drop-down for a user to choose whether they are selecting the quarterly Error and Acknowledgement files or the monthly Query Result Files. Customers may choose to download either the Excel File or the Text File.

When you click on the link, the files will be in a .zip file and when you extract the file, it will be either a .csv or .txt file.

Files will remain on the website for two years.

Below are the file names of the query result files that will be posted to the Account Management page of the ISO ClaimSearch website.

1. Zip file name (csv)– Query_<RRECode>_<date (MMDDYYYY)>_<sequence number>_csv.zip
2. CSV file name – Query_<RRECode>_<date (MMDDYYYY)>_<sequence number>.csv
3. Zip file name (txt)– Query_<RRECode>_<date (MMDDYYYY)>_<sequence number>_txt.zip
4. TXT file name - Query_<RRECode>_<date (MMDDYYYY)>_<sequence number>.txt

Examples:

Query_999999999_10162009_01.csv.zip

Query_999999999_10162009._01.csv

Query_999999999_10162009_01.txt.zip

Query_999999999_10162009._01.txt

NOTE: Large files will be broken up into multiple smaller files. The sequence number 01, 02, etc...will be added to distinguish multiple smaller files for the same date.

NOTE: *Some companies have asked if the file download process can be automated. At this time, it is not possible; an actual user must log into the site to download the file. ISO will consider a future enhancement to return the query result files via FTP.*

The file will contain only individuals that were identified as Medicare recipients; it will not contain all of the individuals that were queried. ISO will maintain in its internal logs the first date a query was performed and the most current date that a query was performed in an audit trail in case it ever becomes necessary to prove that individuals were queried.

See Appendix B for the layout of the query result file.

Timeline for Beginning Queries

ISO began sending querying production files for customers who have completed the ISO registration process in November 2009. ISO will query all claims currently on the production database that qualify for the query and will provide the results as described above. Customers should use these results to update claims that need to be reported to CMS with the Medicare eligible indicator = yes and other CMS required fields for reporting.

As mentioned above, ISO has been querying claims since November 2009. If your company has not received query results yet, it could be for several reasons:

1. You have not reported any applicable type claims to ISO ClaimSearch with all the required fields for querying. (The only required fields which may be missing are the SSN or HICN and Date of Birth since the Name is required by ISO ClaimSearch and a Gender of "unknown" is acceptable).
2. Your group, company or office has multiple RRE codes, so ISO cannot derive the code for you and you have not added the RRE code to each claim to be queried.
3. You report through a TPA and the TPA hasn't added the RRE code to each claim to be queried.
4. Your query transmissions are failing due to missing designees or improper or incomplete registration with CMS.

CLAIMS REPORTING OVERVIEW

Reporting to Medicare through ISO is through enhancements and adaptation of the existing ISO ClaimSearch Universal Format reporting method. Claims to be reported to CMS must be accepted in ISO ClaimSearch before any CMS query or reporting processes can take place. Claim reports that are rejected from ClaimSearch reporting must be corrected and re-submitted to ISO ClaimSearch to be queried by, or submitted to CMS. ISO does not provide the ability to report direct to CMS without reporting to ISO ClaimSearch. Simply report claims as usual to ISO ClaimSearch using Universal Format, and notify ISO of the Medicare-eligible claimants including the CMS required data elements. ISO ClaimSearch will forward any Medicare-eligible claimants to CMS automatically. ISO ClaimSearch will send the claim reports to CMS according to the schedule established by CMS for each responsible reporting entity (RRE).

Companies will be able to report and update claims using either system-to-system connections to ISO ClaimSearch or the ISO ClaimSearch web reporting application. The ISO ClaimSearch website contains all of the data fields CMS requires, and companies will see an indicator next to the CMS-required fields.

ISO ClaimSearch Required Fields for Casualty Claims

In order to add a claim to the ISO ClaimSearch database, the following fields are required. Some of these fields are also used in reporting to CMS as indicated below. See Appendix F for the mapping of ISO fields to the CMS layout.

- **ISO Reporting Code** – will be linked to RRE codes provided in ISO registration process.
- **Claim Number** – Claim Number will be reported to CMS.
- **Policy Number** – Policy Number will be reported to CMS.
- **Date of Loss** (not to be confused with CMS Date of Incident) – Date of Loss will be reported to CMS as the Industry Date of Incident.
- **Insured Name** - Insured name will be reported to CMS.
- **Insured Address** (Street, City, State) – These fields are NOT reported to CMS.
- **Claimant Name** (may be the same as the insured) – Claimant Name is a CMS-required field.
- **Claimant Address** (Street, City, State) - These fields are NOT reported to CMS.
- **Alleged Injury** (as described by claimant) - The injury to the involved party (up to 50 characters). This field is required by CMS through 12/31/10 if there is no Alleged Cause of Illness/Injury Code or ICD-9 Code provided. As of 1/1/11 ISO is no longer passing this field to CMS, but you must continue to report this field on your ClaimSearch Universal Format reports because this field is still required by ClaimSearch.
- **Location of Loss State** – This field is NOT reported to CMS.

ISO ClaimSearch Optional Fields Required for CMS Reporting

- **Gender** - Gender is a CMS-required field. If no gender is reported, ISO will pass "unknown" which is an acceptable gender for CMS reporting.
- **Date of Birth** – Date of Birth is a CMS-required field.
- **Social Security Number** – SSN is a CMS-required field, unless the HICN is reported.
- **Service Providers (Representatives)** – Roles for representatives that may be reported as Service Providers to ISO include the legal roles (Claimant Lawyer, Insured Lawyer, Law Office, Law Office Manager, Lawyer-Other, Paralegal, Lawyer for CMS), Guardian, Power of Attorney and Other. Fields that will be sent to CMS include the individual name, business name, TIN,

address and phone number of the service provider (representative). The name, address and phone number are required by CMS. Since CMS only allows one representative and ISO ClaimSearch allows multiple, we will use a hierarchy when choosing which representative to send to CMS. If the "Lawyer for CMS" role is chosen, that representative will automatically be sent to CMS even if required fields are missing. If no "Lawyer for CMS" role exists, we will look for any other lawyer that has all CMS required fields and will send the first one we find with complete information. If no lawyers with complete information exist, we will look for the first guardian, power of attorney or other role we find with all CMS required fields.

CMS Required Fields (Recently Added to ISO ClaimSearch)

All CMS fields that were not already included in ISO ClaimSearch have been added to the Universal Format and XML layouts and to the ISO ClaimSearch data-entry website. These fields are currently in ISO's test and production environments. The additional CMS fields which were added are optional, as the ISO ClaimSearch process is primary.

The additional data elements added at the claim level include:

- **Self Insured Indicator** - to be used by TPAs; for insurers and non-insurers, this will be derived by your company's membership to ISO ClaimSearch. TPAs should report "YES" if it is a self-insured claim and "NO" if it is not a self-insured claim.
- **COBC Assigned Section 111 Reporter ID (RRE Code)** - If you are an insurer or self-insured company (group, company or office) with only one responsible reporting entity (RRE) code registered at either the group, company or office level, you do not need to report this information on each claim; it will be stored in ISO's membership system and will automatically be associated with each claim. *If your group/company/office has more than one RRE code, you will need to populate this field on each claim to be queried or reported to CMS. TPAs will always have to report the RRE code, even if the TPA has only one RRE code associated with it.*
- **TIN** - For insurers and self-insured companies, if your group/company/office has only one TIN registered for each RRE, you do not need to report this information on each claim; it will be stored in ISO's membership system and will automatically be associated with each claim. *If your group/company/office has more than one TIN, you will need to populate this field on each claim to be reported to CMS. TPAs will always have to report the TIN, even if a TPA has only one TIN associated with it.*
- **SITE ID** - For insurers and self-insured companies, if your group/company/office has only one SITE ID associated to a particular TIN, you do not need to report this information on each claim; it will be stored in ISO's membership system and will automatically be associated with each claim. *If your group/company/office has more than one SITE ID per TIN, you will need to populate this field on each claim to be reported to CMS. TPAs will always have to report the SITE ID, even if a TPA has only one SITE ID associated with it.* SITE ID is a numeric only field.

  NOTE: *RRE Codes, TINs and SITE IDs are maintained in ISO's membership system. ISO must be notified of any additions or changes to these codes/IDs.*

The additional data elements added at the claimant level include:

- **Medicare Eligible Indicator** - This field should be populated with "YES" if you are aware that this involved party is Medicare eligible and if you would like this claimant to be reported to CMS. You

may choose "NO" if you wish to report that the person is not Medicare eligible, or you can leave this field blank for any claimants that do not need to be reported to CMS. Entering "YES" will stop the monthly query on this party. The Medicare eligible indicator = "yes" is the main trigger for CMS reporting. Only claimants marked with this indicator will be reported to CMS.

- **'Do Not Send this party to CMS' Indicator** - If you mark the claimant as Medicare Eligible = "YES" but do not want the claim sent to CMS, you may send the 'Do not send this party to CMS' indicator. You may do this because the claim amount is below the required dollar threshold, coverage has not been confirmed, or if you do not have all required fields and do not want to receive a CMS rejection. If this indicator is checked, this claimant will not be reported to CMS until the indicator is removed. Please note that this indicator does not stop the person from being queried. If you enter this indicator after the claim has been sent to CMS, ISO will send a delete transaction to CMS.
- **Injured Party HICN**-This field allows you to enter the Medicare Health Insurance Claim Number (HICN), for the injured party on a claim. HICN is required if the SSN is not reported. CMS advises that once a HICN is provided through a query response file, it must be used on all future submissions. You must add the HICN to your claim on the ClaimSearch database in order for it to be reported on future submissions.
- **Stop Querying CMS to determine Medicare eligibility for this party** – This field allows you to choose when to stop querying a claimant for eligibility outside of the parameters in which ISO normally stops querying. You may wish to stop the query if the claim is closed and you do not expect to have further responsibility.

The additional elements added at the coverage level include:

- **Date of Incident (DOI) as defined by CMS:** For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure (including, for example, Occupational Disease and any associated cumulative injury) the CMS DOI is the date of first exposure. For claims involving ingestion (for example, a recalled drug), it is the date of first ingestion. For claims involving implants, it is the date of the implant (or date of the first implant if there are multiple implants). The CMS Date of Incident for these claims is often different than the date of loss or incident used by insurers under current practice, which generally involves last exposure.
- **State of Venue** - Enter the US Postal abbreviation corresponding to the state whose law controls resolution of the claim such as in certain no-fault statutes. Insert "US" where the claim is a Federal Tort Claims Act liability insurance matter or a Federal workers' compensation claim. Enter "FC" in the case where the State of Venue is outside the United States. The state of venue may be different than the Loss Location field in ISO ClaimSearch.
- **No Fault Insurance Limit** - This field requires that you enter the dollar amount of the limit on no-fault insurance. Please do not enter dollar signs, commas, or decimals. Dollars and cents are to be reported. Fill with nines if there is no dollar limit such as a workers' compensation no-fault state with a time limit or monetary policy limit. Leave blank if Plan Insurance is Workers Compensation or Liability Insurance (including Self-Insurance). "No Fault" Insurance means insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans.
- **Exhaust Date for Dollar Limit for No-Fault Insurance** - This field allows you to enter the date on which the limit was reached or benefits exhausted for No-Fault Insurance. Leave blank if No-

Fault limit has not been reached/exhausted or if the Plan Insurance Type is Workers Compensation or Liability Insurance (including Self-Insurance). This field should not be populated until the No-Fault insurance limit is exhausted. It should not be a future date.

- **On-Going Responsibility for Medicals (ORM) Indicator** - This field should be used to indicate if there is an ongoing responsibility for medicals. Report 'YES' if you do have ongoing responsibility and 'NO' if you do not have ongoing responsibility. This field is passed to CMS, but is not used by ISO to determine whether to send your claim according to the ORM or TPOC rules. ISO derives whether your claim should be treated as ORM or TPOC based on the policy, coverage and loss type reported. Based on recent errors seen on CMS result files, ISO will no longer send claims which are mapped to an ORM policy, coverage and loss type to CMS if you mark the ORM Indicator as "NO". The claim will not be sent until you change the indicator to "YES" or report a TPOC date.
- **On-Going Responsibility for Medicals (ORM) Termination Date** - This field should be populated with the date that the ongoing responsibility for medicals ended, where applicable. This field should only be entered if you have previously checked this claim as an ORM. An ORM termination date may not be the date the claim is settled. It is the period of time in which a policy will respond for claims for the same incident. Future dates are accepted but should not be more than 6 months greater than the file submission date. *For ORM claims, the claim will be sent to CMS as an ADD record when the claimant is first marked as Medicare eligible, and it will be sent as an UPDATE record when the ORM Termination Date is provided.*
- **Total Payment Obligation to the Claimant (TPOC) Date -** (Max 5) - Date payment obligation was established through settlement, judgment, award or other payment; this is the date the obligation is signed if there is a written agreement, unless court approval is required. If court approval is required, it is the later of the date the obligation is signed or the date of court approval. If there is no written agreement (settlement), it is the date of the first payment when there will be multiple payments or settlement date when there is only one settlement payment. If you have more than 5 TPOCs, the 6th and subsequent TPOCs should be added to TPOC 5. The most recent date should be reported in the TPOC 5 date field. *For TPOC claims, the claim will be sent to CMS as an ADD record when both the claimant is marked as Medicare-eligible and the TPOC Date is provided.*
- **Total Payment Obligation to the Claimant (TPOC) Amount** - (Max 5) – This field is to be filled with the settlement amount of the claim for the claimant. In regards to the TPOC Amount, if there is a structured settlement, the amount is the total payout amount. If a settlement provides for the purchase of an annuity, it is the total payout from the annuity. For annuities base the total amount upon the time period used in calculating the purchase price of the annuity or the minimum payout amount (if there is a minimum payout), whichever calculation results in the larger amount. Please do not enter dollar signs, commas, or decimals. Dollars and cents are to be reported. If you have more than 5 TPOCs, the 6th and subsequent TPOC amount should be added to TPOC 5. In most cases, the TPOC amount is the settlement amount.
- **Funding Delayed Beyond TPOC Start Date -** (Max 5) - If funding for the Total Payment Obligation to the Claimant is delayed, provide the actual or estimated date of funding. Fill with zeroes if not applicable. If you have more than 5 TPOCs, the 6th and subsequent TPOCs should be added to TPOC 5. The most recent date should be reported in the 5th Funding Delayed field.
- **ICD-9 Codes** - (Max 19) (Internal Classification of Diseases, Ninth Revision, Clinical Modification) Diagnosis Code describing the alleged injury/illness. CMS requires five (5) digit ICD-9 Codes. The ISO ClaimSearch field is defined as six (6) digits. When entering this field, you may include the decimal. If you do, the decimal will be stripped on the file sent to CMS. If an ICD-9 code is less than five digits, ISO will send the appropriate number of spaces at the end of the code to

equal the required five bytes. CMS requires at least one ICD-9 Diagnosis code for new or updated records submitted on or after 1/1/11. At least one valid diagnosis code must be sent and it must not be an E code and not be a V code. CMS will review the accuracy of ICD-9 codes to injuries provided, so care in selection is recommended. Please refer to CMS's list of insufficient ICD-9 Diagnostic Codes in Appendix H of CMS's manual (Version 3.1). ISO compiled and condensed the reportable ICD-9 (including the new NOINJ code to be used in rare instances to report "no injury") codes into an Excel spreadsheet available on the ISO ClaimSearch website. The list includes all revisions to the ICD-9 codes that CMS allows. In addition, in ClaimSearch claims reporting, ISO developed a look up function where a user entering or updating a claim, can search for an ICD-9 code based on a word or a phrase. ISO developed these features based on the CMS recommended reference sites:
http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf,
http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm,
www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp
NOTE: For customers with system-to-system interfaces using the Universal Format text file layout, if ICD9 codes are reported on both the UC01 record and UEX3 record, the codes from the UEX3 record will be sent to CMS. If less than 19 ICD9 codes are reported on the UEX3, remaining ICD9s would be populated from the UC01 record.
SEE APPENDIX H FOR MORE TIPS ON REPORTING ICD-9 CODES

- **Alleged Cause of Injury Code** - Enter the ICD-9-CM External Cause of Injury Code, "E Code" describing the alleged cause of injury/illness. CMS requires five (5) digit Cause of Injury Codes. Do not enter the decimal. If a Cause of Injury code is less than five bytes, ISO will send the appropriate number of spaces at the end of the code to equal the required five bytes. CMS requires the Cause of Injury code on all new or updated records submitted on or after 1/1/11. Please refer to CMS' list of insufficient ICD-9 Diagnosis codes in Appendix H of CMS's manual (Version 3.1). ISO compiled and condensed the reportable ICD-9-CM (including the NOINJ code) codes into an excel spreadsheet available on the ISO ClaimSearch website. The list includes all revisions to the ICD-9-CM codes that CMS allows. In addition, in ClaimSearch claims reporting, ISO developed a look up function where a user entering or updating a claim, can search for an ICD-9-CM code based on a word or a phrase. ISO developed these features based on the CMS recommended reference sites:
  http://www.cdc.gov/nchs/icd/icd9cm.htm
  http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp
  SEE APPENDIX H FOR MORE INFORMATION ON REPORTING CAUSE OF INJURY CODES.
- **Delete this party/coverage from CMS Indicator** – Marking this field as "YES" will send a delete transaction to CMS for this individual. CMS instructs that the delete transaction should only be used in rare instances when an original record should never have been sent in the first place. If you mark this indicator prior to your claim being sent to CMS, ISO will not send the claim to CMS.
- **Do not send this coverage to CMS Indicator** – Marking this field as "YES" will prevent this claimant/coverage from being sent to CMS. You may do this because the claim amount is below the required dollar threshold, coverage has not been confirmed, or if you do not have all required fields and do not want to receive a CMS rejection. If this indicator is checked, this claimant/coverage will not be reported to CMS until the indicator is removed. Please note that this indicator does not stop the person from being queried. If you enter this indicator after the claim has been sent to CMS, ISO will send a delete transaction to CMS.
- ***Product Liability Indicator** - If the involved party is injured as a result of or involves a defective product, you may indicate this by selecting 'YES, this claim is a product liability but not a mass

tort' or 'YES, this claim is a mass tort claim and a product was involved in the injury' or 'NO' if this is not a product liability claim. Note: product liability claims should be entered as coverage and loss type when reporting the claim to ClaimSearch. The indicator (which is currently not required by CMS until further notice) may reflect a product defect which may be contributory to a claim for Workers' Compensation or No-Fault.

- ***Product Generic Name** – The generic name of the product alleged to be the cause of injury, illness or incident. If no generic name is applicable, supply the brand name. .
- ***Product Brand Name** – The brand name of the product alleged to be the cause of injury, illness or incident. .
- ***Product Manufacturer** – The maker of the product. .
- ***Product Alleged Harm** - This is a free-form text field that provides the opportunity to enter a more detailed description of the harm allegedly caused by a product (maximum 200 characters). This field is required by CMS now if the Product Liability is a mass tort situation.

*The requirements for Fields 58-62 on the Claim Input File Detail Record are currently under review by CMS. These fields will be filled with spaces by ISO until revised requirements are published.

You will note that some fields appear either duplicative or contradictory, such as the CMS Date of Incident vs. Date of Loss or TPOC Amount vs. Settlement Amount. CMS' fields of information are defined differently than those in ISO ClaimSearch. We have added the CMS fields for entry, as opposed to mapping fields with different interpretations.

A mapping of ISO claim reporting fields to CMS reporting fields is included in Appendix F.

See the Universal Format Manual version 7.3 for the layout for Universal Format FTP and MQ customers.

See the XML Manual version 5.3 for the XML specs.

See the User Manual for CMS Reporting Version 3.3 for the instructions to report CMS claims via the ISO ClaimSearch website.

Required Field Warnings

We have added a "CMS required field" warning notification to the ISO ClaimSearch output records and match reports to notify participants of missing or invalid CMS required fields.

When companies mark claimants as Medicare-eligible, the system will screen the claims to identify missing or in some cases, invalid CMS-required fields. If fields are missing or invalid, ISO ClaimSearch will provide a warning indicator. For companies who receive web returns, the warning indicator will show on the SUMMARY SCREEN indicated by a red exclamation point. See below:

Reports | Claim Submission | APD FastCheck | Preferences

'Submitted Report +' means that no matching claims were found, however, NCIC and/or Shipping information is contained within the report.

Your office has unread reports more than 15 days old. Click 'View All Office Reports' to see these reports.

Print New | Print Selected | Delete Selected | View All Office Reports

	Select	Report Date	Type	Adjuster	Score	Claim Number	Routing
1)	☐	07-10-2009	Match Report	BERKOWITZ,BRYAN,L		12313 NEW !	
2)	☐	07-10-2009	Match Report	BERKOWITZ,BRYAN,L		12313 !	
3)	☐	07-10-2009	Submitted Report Only	BERKOWITZ,BRYAN,L		12345 !	
4)	☐	07-10-2009	Match Report	BERKOWITZ,BRYAN,L		12313	

For web, PDF or XML customers who use the style sheets provided by ISO, the warning message(s) will appear within the ISO ClaimSearch match report in the summary section for the involved party. See the example below in which Matthew Bryant was reported as Medicare-eligible and has warning messages for missing SSN or HICN.

Reports | Claim Submission | APD FastCheck | Preferences

Print Back to reports list

ISO CLAIMSEARCH MATCH REPORT SUMMARY

A claim report identified by ClaimSearch identification number 8I000442918 was received by ISO ClaimSearch on 7/9/2009 as a Replacement of a previously submitted claim. Submission of this replacement claim initiated a search of the ClaimSearch database. The claim(s) listed below appear(s) to be similar to the claim submitted. Reasonable procedures have been adopted to maximize the accuracy of this report. Independent investigations should be performed to evaluate the relevant data provided.

If you have any questions concerning your report, please contact Customer Support at (800) 888-4476.

INITIATING CLAIM INFORMATION

Claim Number: 12313 **Date of Loss:** 06/16/2009
Policy Number: 12313 **ISO File Number:** 8I000442918

SUMMARY FOR EACH SEARCHABLE PARTY

BOB'S CONSTRUCTION, INSURED
No matches for this party

MATTHEW BRYANT, CLAIMANT
** This Person is Medicare Eligible. **

Coverage: Indemnity **Loss Type:** Indemnity
Missing CMS Required Field: Injured Party HICN or Injured party SSN is required

If your company participates in the optional ClaimDirector service, the warnings will appear within the actual match report since ClaimDirector result reports do not have the summary shown above.

For customers who receive FTP or MQ returns, the warning messages will appear on the MCMS record. Your company will need to do additional programming to read this new record type. For XML customers, the warning messages will appear on a new aggregate, CMS Warning <com.iso_CMS>.

If an invalid entry is sent to ISO ClaimSearch for one of these fields (ex: if all 9s are submitted as an SSN), that field will be blanked out by ClaimSearch. These fields will be considered blank for CMS purposes and will be subject to the CMS warning messages.

The system will provide the warning when the company first marks the claim as Medicare eligible and each time the company replaces the claim to add additional information. Because the warnings are shown on match reports, they will not be generated if the 'Submit Claim Only – Do Not Search' indicator is checked on the web or if the 'No Search' indicator is checked for system-to-system companies since no match reports are generated in those instances. Warnings are also not generated when the update transactions are used vs. the replacement transactions (for system-to-system companies) because updates do not perform searches or generate match reports. At this time, warnings are also not provided on Research records; ISO will consider this as a future enhancement. Currently, warnings only occur for searchable involved parties submitted on Initials or Replacements.

The warning indicators will give your company the chance to update the claim with the missing fields before the scheduled CMS quarterly submission period. The warnings do not prevent the claims from being sent to CMS at the designated reporting period, however. If the fields are not added to the claims, the reports will still be sent to CMS as part of the quarterly reporting requirement.

ISO ClaimSearch is not validating all fields based on CMS edits. ISO does not know all of the validations that CMS may perform on required fields. The warnings are to provide you with information on missing CMS required fields or fields with apparent invalid values; it is not a guarantee that CMS will accept your claim once these fields are provided.

NOTE: *Some customers do not want claims to be sent to CMS that they know will reject. If your company does not want claims to be sent to CMS that you know will reject, you may check the 'Do not send to CMS Indicator' to prevent the claim from being sent.*

The screening service includes rules for reporting contingent fields. This means that if certain conditions exist, there is a requirement to report these conditions to CMS through ISO ClaimSearch. For example, information on the claim representative isn't always required, however, if your company reports a representative such as an attorney, the individual or business name and address and phone number are required.

See next page for a complete list of required field warnings.

NOTE: In the case of multiple additional claimants or multiple representatives for an injured party or additional claimant, ISO is unable to indicate which specific parties are missing the required information; it may be only one party, or it may be multiple parties. The messages below (06-13, 28-42) alert you to the fact that at least one party is missing information. In some instances, that party may not be the individual that will be sent to CMS. EX: CMS can only accept one Representative for an Injured Party or Additional Claimant. ISO uses a hierarchy in deciding which Representative to send to CMS. For example, if a lawyer and guardian are sent on input, only the lawyer will be sent to CMS. In this example, the lawyer may or may not be the individual the warning was generated for.

ISO has also created a management report to provide users with access to any claims that contain the ISO ClaimSearch CMS warnings. This report gives users the ability to see which claimants they have marked as Medicare eligible but have missing CMS required fields. For further information, see the ISO ClaimSearch MSP Account Management section of this manual.

CMS REQUIRED FIELD WARNINGS GENERATED BY ISO CLAIMSEARCH

Code	Warning Message
01	RRE Code Missing or Invalid
02	TIN Missing or Invalid
03	Site ID Missing or Invalid
04	Injured Party HICN or Injured party SSN is required
05	Injured Party DOB missing or Invalid
09	One or more Injured Party Representative Mailing Address Missing or Invalid
12	One or more Injured Party Representative Zip Code Missing or Invalid
13	One or more Injured Party Representative Phone Missing or Invalid
14	Self Insured indicator Missing or Invalid – required for liability & workers comp claims (required only for TPAs).
15	Date of Incident Missing or Invalid
16	State of Venue Missing or Invalid
17	No-Fault Insurance Limit Missing or Invalid
18	ORM Indicator Missing or Invalid
19	TPOC Amount Missing or Invalid
20	Alleged Cause of Injury, Incident or Illness Missing or Invalid
21	ICD-9 Diagnosis Code Missing
27	ICD-10 Diagnosis Code Missing or Invalid (future)
28	One or more Additional Claimant Individual/Business Indicator Missing or Invalid
29	One or more Additional Claimant Business Name Missing or Invalid
30	One or more Additional Claimant Last Name Missing or Invalid
31	One or more Additional Claimant First Name Missing or Invalid

Code	Warning Message
32	One or more Additional Claimant SSN or TIN Missing or Invalid
34	One or more Additional Claimant Mailing Address Missing or Invalid
35	One or more Additional Claimant City Missing or Invalid
36	One or more Additional Claimant State Missing or Invalid
37	One or more Additional Claimant Zip Code Missing or Invalid
38	One or more Additional Claimant Phone Missing or Invalid
40	One or more Additional Claimant Representative Mailing Address Missing or Invalid
41	One or more Additional Claimant Representative Zip Code Missing or Invalid
42	One or more Additional Claimant Representative Phone Missing or Invalid
44	TPOC date 1 must be greater than the CMS Date of Incident.
45	TPOC date 2 must be greater than the CMS Date of Incident.
46	TPOC date 3 must be greater than the CMS Date of Incident.
47	TPOC date 4 must be greater than the CMS Date of Incident.
48	TPOC date 5 must be greater than the CMS Date of Incident.
49	Total of all TPOC amounts is below dollar threshold
50	ICD-9 Diagnosis Code 1 is Invalid
51	ICD-9 Diagnosis Code 2 is Invalid
52	ICD-9 Diagnosis Code 3 is Invalid
53	ICD-9 Diagnosis Code 4 is Invalid
54	ICD-9 Diagnosis Code 5 is Invalid
55	ICD-9 Diagnosis Code 6 is Invalid
56	ICD-9 Diagnosis Code 7 is Invalid
57	ICD-9 Diagnosis Code 8 is Invalid
58	ICD-9 Diagnosis Code 9 is Invalid
59	ICD-9 Diagnosis Code 10 is Invalid

Code	Warning Message
60	ICD-9 Diagnosis Code 11 is Invalid
61	ICD-9 Diagnosis Code 12 is Invalid
62	ICD-9 Diagnosis Code 13 is Invalid
63	ICD-9 Diagnosis Code 14 is Invalid
64	ICD-9 Diagnosis Code 15 is Invalid
65	ICD-9 Diagnosis Code 16 is Invalid
66	ICD-9 Diagnosis Code 17 is Invalid
67	ICD-9 Diagnosis Code 18 is Invalid
68	ICD-9 Diagnosis Code 19 is Invalid
69	TPOC claim has ORM indicator = Y. Change to N. If needed add ORM coverage/loss with ORM = Y.
70	ORM claim was entered with ORM indicator = no. Claim will not be sent to CMS until ORM indicator = yes or until TPOC date is entered.
71	No fault limit exceeds $99,999,999.99
72	Total of TPOC amounts exceed $99.999.999.99

Types of Claims to be Reported

Claim reporting for CMS is based on the claimant and the coverage. All liability, workers compensation medical (and related statutory insurance programs) and all medical payment-type coverages (referred to by CMS as No Fault claims), must be reported to CMS.

Reporting requirements to MMSEA Section 111 involve payment to a Medicare recipient of medical bills that apply to a claim for first party medical payments or Workers Compensation, and/or all liability bodily injury claims including or separately processed medical payments

See Appendix A for a chart showing which ISO Policy, Coverage and Loss types qualify for CMS reporting.

No-Fault Insurance and Workers' Compensation Claims (ORM Claims)

Examples of ORM claims are Auto no-fault or medical payments, premises medical payment and workers compensation medical.

A report for No Fault claimants must be reported with the acceptance of coverage or payment. Required fields of information must be reported in the quarterly file, but conditional required fields must be reported when known. Conditionally required fields are those that are required if the condition presents itself:

- Self insurance – if the risk is self insured vs. an insurance policy covers the risk for the claim involved.
- Representative (if known),

The ORM Indicator in ISO ClaimSearch is to be selected as "YES". Once this indicator is selected, it should remain for the life of the claim unless the claimant loses his/her medical recipient status.

Claimants with ORM will be reported at least twice to CMS. ISO will report the ORM claims to CMS based on the following rules:

- When there is a claim for medicals paid or accepted and your company submits a claim with a Medicare-eligible indicator set to "yes", ISO ClaimSearch will send the claim to CMS as an "add" record (Action Type "0").

- When your company changes a key field, ISO ClaimSearch will send the claim to CMS as a "delete" record (Action Type "1") followed by a new "add" record (Action Type "0"). Key fields include CMS Date of Incident, Plan Insurance Type and ORM Indicator.

- For claims already accepted by CMS, if you report the "Do not send to CMS" indicator at either the claimant or coverage level, remove the Medicare eligible indicator or change the indicator to "no", change the coverage to a non-CMS reportable type, or if the claim is voided from the ISO ClaimSearch database, ISO will send a "delete" record (Action Type "1") to CMS.

- When your company updates any fields that CMS designates as "important", ISO ClaimSearch will send the claim to CMS again as an update (Action Type "2"). Important fields include ICD-9 codes, TIN, TPOC Date, TPOC Amount, Additional Claimant Information, ORM Termination Date.

- When your company provides the ORM (ongoing responsibility for medicals) termination date, ISO ClaimSearch will send a final claim to CMS as an "update" record (Action Type "2"). The ORM termination date is when the responsibility for medical payments ends. **NOTE:** Termination

of Ongoing Medical responsibility is not necessarily when all medical has been paid. The termination date reflects the date when the company's duty to pay any medical claim by policy or statute ends. Future dates are accepted but should not be more than 6 months greater than the file submission date.

- **Single Payment Liability Claims (TPOC Claims)**

TPOC (total payment obligation to the claimant) claimants are only to be reported after the claim is settled through settlement, judgment or award. The TPOC indicator will include the date and amount of the settlement.

ISO will report the TPOC claims to CMS based on the following rule:

- When your company marks the claimant as Medicare eligible and provides the TPOC (total payment obligation to the claimant) date, ISO ClaimSearch will report the claim to CMS as an "add" (Action Type "0").
- ISO will send an update (Action Type "2") when additional TPOCs are added.

Claim Scenarios

- Reports to ISO ClaimSearch for CMS reporting are on the claimant and coverage level. The Medicare eligible indicator is on the person level. It is possible to have a claimant with a No Fault claim, such as a medical payments claim under a Homeowners Policy, and a Bodily Injury Liability claim in the same claim report. In these instances, the Medical Payments claim is an ORM claim, and the Liability claim is a TPOC claim.

Assuming the claimant is a Medicare recipient, the Medical Payments claim would be reported to CMS with the next quarterly file, to reflect the assumption of coverage or payment of a claim. The ORM indicator would be set to "Yes", but the ORM termination date may not be the date of the last medical, as the responsibility for payment of medicals is still active, per policy period. If the Homeowners policy carried a one year medical payments limitation, when that date was reached, the ORM termination date would be submitted.

The liability claim would not be reported to CMS until the claim was paid, through settlement, judgment or award. At the date the payment for settlement is made, the TPOC date and amount is entered. Once that information is entered in ISO ClaimSearch, a report is triggered to CMS on this claimant at the next quarterly reporting period. Note: The ORM Indicator continues to be set to "Yes".

- Mass Tort reporting: At this time, CMS has not advised the procedure under which a mass tort claim is to be reported. True Mass Tort claims involve many insurers, defendants, defense counsels, adjusters and claimants. The common thread is the cause of injury; related to a common injury or product, alleged to be defective, or the source of an occupational illness. Most of these cases are in litigation, with plaintiff counsel maintaining the list of plaintiffs. This list is usually unknown to the insurer until the mass tort is settled and the claim being paid or settlement certified under court order. At that time, the information involving the plaintiff's Medicare status can be developed. Issues involving which RRE reports the claimant is under advisement by CMS.

ISO has included a mass tort indicator and related litigation fields such as State of Venue, Location and Docket Number. State of Venue is the only CMS required field if the claim involves other state legislation.

It is currently a requirement for all insurers to report claimants who are Medicare recipients that either are paid medicals (ORM), or TPOC. If this applies to Mass Tort claims, all insurers that have been named in the action will be required to report to CMS once the settlement of these claims has been reached. **NOTE**: MMSEA, Section 111 does not include reporting of liability claims until settlement, judgment or award.

Other CMS reporting requirements are not discussed in this manual.

COMBINING NO-FAULT "PLAN D" COVERAGES

CMS has indicated that if more than one No-Fault "Plan D" coverage is reported, both coverages should be combined into one record when reported to CMS. Since many ISO ClaimSearch customers report multiple coverages, for example, you may report a PIP and Med Pay coverage for the same person, ISO will now combine those into one submission to CMS. To do so, ISO has developed the requirements below which will be used to combine multiple No-Fault coverages if they were reported separately to ISO ClaimSearch.

REQUIREMENTS FOR COMBINING CLAIMS FOR PLAN INSURANCE TYPE D

If more than one reported coverage maps to Plan Insurance Type D, we will combine the coverages and report one claim to CMS.

- If different dates of incident are reported, we will keep the earliest date.
- If there are different states of venue, we will keep the one that is reported with the date we used above. If there are multiple records with the same date but different states, we will take the first state reported for that date.
- All no fault insurance limits will be added together.
- For exhaust date, we will pick the latest date reported.
- For the ORM indicator, if at least one is "yes", we will send "yes". If all are "no", we will send "no".
- For the ORM Termination date, we will pick the latest date reported.
- For TPOC dates, amounts and funding delayed dates, we will send the first 5 reported.
- For ICD9 codes, we will send up to the first 19 unique ICD9s reported.
- For Cause of Injury, we will send the first one reported.

For Key Field Changes:

- If any date of incident is changed, we will find the earliest date. If the earliest date is the same as what was sent; do nothing. If different, send an update record.
- If any ORM indicator changes, if "yes" was originally reported, check to see if all are now "no". Only send an update if all changed to "no". If "no" was originally reported, check to see if any are now "yes" and only send an update if at least one is now "yes".
- Claim Type – if a claim type changes to a non-CMS type, we don't do anything unless the customer first sent a Delete from CMS transaction prior to changing the type.

Important Field Changes:

- If an ICD9 changes, we will send an update if any of the first 19 are different than what was sent before.
- TPOC Date, Amount & funding delayed dates, if any of the first 5 change, we will send an update.

Delete this Party/Coverage from CMS Indicator:

- If all records have the delete indicator, we will send a delete transaction.
- If the delete indicator is not on every coverage, we will send the delete transaction, but will then send a new Add record for any coverages that didn't contain the delete transaction.

Do Not Send this Coverage to CMS Indicator:

- If all records have this indicator, we will not send a transaction to CMS.
- If this indicator is not on every coverage, we will send an Add record for any coverages that didn't contain the indicator.
- If an add record was already sent to CMS and this indicator is later removed from a coverage that was not sent originally, we will send a combined record as an update to add this additional coverage information to the claim.

NOTE: On the Acknowledgement and Rejection file you will receive once your file has been processed, for any Plan D claim you reported, the coverage and loss type which will be displayed on the output file will be COMB/COMB. Currently, even if you only reported one No-Fault type coverage, the result file will still show COMB/COMB indicating that it was a "combinable" type. The original coverage and loss type reported will not be shown.

Thresholds

CMS has announced thresholds. If a claim falls below the threshold, it is not required to report the claim to CMS. The thresholds are listed below. ISO will provide a warning if the total of all TPOC amounts are below the current threshold. It is the company's responsibility to prevent sending a claim to CMS which falls below the threshold. If a claim is below the threshold and you do not want to send the claim to CMS, you can either not mark the Medicare-eligible indicator, or, if you do mark the indicator, you must also select the 'Do not send to CMS' indicator at the involved party level or the "Do not send this coverage to CMS" indicator at the coverage level in order to prevent your claim from being sent to CMS.

Ongoing Responsibility for Medicals (ORM): Workers' Compensation only

- Includes all medical payments coverage
- Reporting is required at first payment or acceptance of coverage and at termination of reporting responsibility
- Report any open ORM claim as of 1/1/10
- Threshold for WC medical claims is $750 with lost time less than 7 days

Total Payment Obligation to the Claimant (TPOC)

- Third party liability claims
- Report at closing: settlement, judgment or award or other payment
- Threshold; total payments:

TPOC AMOUNT Mandatory to be reported	TPOC Date Between	Minimum TPOC Amount	Required to be reported beginning
Over $100,000	10/1/11 – 3/31/12	$5000	1st Quarter 2012
Over $50,000	4/1/12 – 6/30/12	$5000	3rd Quarter 2012
Over $25,000	7/1/12 – 9/30/12	$5000	4th Quarter 2012
Over $5000	10/1/12 – 12/31/12	$5000	1st Quarter 2013
Over $2000	1/1/13 – 12/31/13	$2000	2nd Quarter 2013
Over $600	1/1/14 – 12/31/14	$600	2nd Quarter 2014
Over $0	1/1/15 – indefinite	$0	2nd Quarter 2015

- Reporting is required for all liability claims open as of 10/1/11
- "Look back period" is 12/5/1980 for open Liability and No-Fault claims. There is no look-back period for Workers' Compensation claims.

Please be advised that ISO does not look at the threshold dates or amounts when sending to CMS. If you have marked the Medicare-eligible indicator = yes and have entered a TPOC date, ISO will send your claim to CMS unless you mark the "Do not send to CMS" indicator.

Timing of Reporting

The timing of reporting the CMS required fields often depends on the type of reporting required. If the claimant has been identified as a Medicare eligible recipient and has submitted a liability claim to the insurer or self insurer, with no request for payment of medicals, the insurer or self insurer (and TPA) may not need to report the claimant to CMS until the claim has been settled.

It is important to know that the claimant is a Medicare recipient early in the process to determine if the CMS required fields must be completed. Remember, a claimant who is not a Medicare recipient at the outset of the claim may become eligible based on the seriousness of the injury, or other factors. It is because of this that ISO ClaimSearch will continue to query the claimant for eligibility until the claimant's status changes to Medicare eligible and the company activates the Medicare eligible indicator. See the Query section of this manual for more information.
Once the claimant is identified as a Medicare recipient, the fields of information required by CMS must be entered prior to the RRE's quarterly reporting period. If the settlement, judgment, award or other payment is within forty five (45) days prior to the start of the RRE reporting timeframe, then you may delay reporting until the next quarterly reporting period.

The company has the ability to add the Medicare eligible status to the claimant's report. The Medicare eligible indicator is the responsibility of the RRE (or organization charged with reporting on behalf of the RRE) to add to the ISO ClaimSearch report.

Even though it has been determined that the claimant is a Medicare recipient, occasionally the claim information to send to CMS has not yet been finalized; claimant SSN, or date of birth have not been obtained; a coverage question may exist, or the claim may not exceed the thresholds mentioned above. In these instances, a company can activate the 'Do not send this party to CMS' indicator or the 'Do not send this coverage to CMS' indicator to give the opportunity to obtain the required fields, determine if the claim exceeds the threshold, or the company has resolved any coverage issues. The claim will not be sent to CMS until the field is updated to reflect the company's intent to send the claim to CMS at the next reporting period.

NOTE: *It is incumbent upon the claims representative to update the 'Do not send this party to CMS' or the 'Do not send this coverage to CMS' indicator. ISO ClaimSearch will not remind the company that the indicator is active on the claim.*

Reporting Periods

ISO will build your quarterly claim file on the first day of your group reporting period. All claims to be included in that quarter's file must be entered into the ISO ClaimSearch system by midnight the day prior to the first day of your reporting window.

Below is a summary of the group reporting dates:

Group 1 January 1, April 1, July 1, October 1

Group 2 January 8, April 8, July 8, October 8

Group 3 January 15, April 15, July 15, October 15

Group 4 January 22, April 22, July 22, October 22

Group 5 February 1, May 1, August 1, November 1

Group 6 February 8, May 8, August 8, November 8

Group 7 February 15, May 15, August 15, November 15

Group 8 February 22, May 22, August 22, November 22

Group 9 March 1, June 1, September 1, December 1

Group 10 March 8, June 8, September 8, December 8

Group 11 March 15, June 15, September 15, December 15

Group 12 March 22, June 22, September 22, December 22

CLAIM REPORTING METHODS

Universal Format Requirement

All claims to be reported to CMS must be submitted to ISO ClaimSearch using the Universal Format reporting method. Only Universal Format includes the additional data elements required by CMS. The legacy formats do not contain the necessary data elements.

There are several methods that may be used to submit claims to ISO ClaimSearch via Universal Format. Customers may report claims via the ISO ClaimSearch website, or may develop a system-to-system interface in order to send a file directly from their claim system. A combination of methods may also be used. If your company currently reports to ISO ClaimSearch using a Universal Format automated feed, but you wish to supplement the information reported through that feed by updating the claims via the web, you will be able to pull up your previously reported Universal Format claims to add the additional necessary fields via the ISO ClaimSearch website. The information you add through the website will not be eliminated by a system Replacement report, but the information can be overwritten by a system Replacement. In other words, a system replacement will not blank out a field previously reported on the web, but a value reported through the web can be changed to a different value using a system replacement.

NOTE: XML Format is an alternate programming format that is the equivalent of Universal Format as the data elements and file processing are the same as Universal Format. References to Universal Format system-to-system reporting can be assumed to include XML Format unless specifically stated otherwise.

Web Reporting

As of July 17, 2009, the ISO ClaimSearch website Universal Format screens were updated to include the new fields of information required by CMS. If your company is familiar with reporting claims via the website, the new screens are very similar to the screens you are already familiar with. Some additional fields were added to existing screens, and a new screen was added for casualty claims. An asterisk (*) appears next to each field which is optional to ISO ClaimSearch reporting but is important for CMS reporting.

As of 1/1/2010, the legacy reporting screens are no longer supported for all customers. On that date, any web reporting company that had not already switched to Universal Format automatically began seeing the Universal Format screens for new claim submissions.

NOTE: *At this time, ISO has only discontinued legacy reporting for new claims entered via the ISO ClaimSearch website. Customers will still be able to send Initial legacy claims via system to system reporting until 12/31/11. Existing legacy companies can continue to send legacy system-to-system updates through 12/31/12 at which time system-to-system legacy reporting of new and existing claims will also be discontinued.*

System-to-System Reporting

For companies who report to ISO ClaimSearch using a Universal Format system-to-system interface (FTP or MQ), updated record layouts were provided in November, 2009 and were again updated in November, 2010. Customers using Universal Format to send to ClaimSearch via FTP or MQ should refer to the Universal Format Manual version 7.3.

Customers reporting via XML Format should refer to the XML Manual version 5.3 which was provided in March, 2011.

All changes for CMS reporting are summarized in the Summary of Changes section at the beginning of the manuals.

Some new fields were added to existing records/aggregates. Additional fields were added in new input records/aggregates. The new fields have also been added to the Echo records/aggregates on output. The new fields will not be displayed to other customers on match reports. In addition to the new input and

echo records/aggregates, a new record/aggregate was added to provide the warning messages for missing CMS required fields.

If your company needs the layouts, please contact the ISO ClaimSearch Database Development group at claimsearchdatabasedevelopment@iso.com.

Testing System-To-System Changes

If your company has an existing Universal Format system-to-system reporting method and is making programming changes to incorporate the new CMS fields, you may contact your designated ISO Testing Representative to arrange testing, or, if you don't know who your representative is, you may contact the ISO ClaimSearch Database Development group at claimsearchdatabasedevelopment@iso.com. Please note that prior to testing CMS functionality your company should complete the ISO Product Supplement and Authorization Forms in order to be set up in the ISO ClaimSearch membership system as CMS participants.

Updating System-to-System Claims via the Web

If your company currently reports to ISO ClaimSearch using a Universal Format automated feed, but you wish to supplement the information reported through that feed by updating the claims, you will be able to pull up your previously reported Universal Format claims to add the additional necessary fields via the ISO ClaimSearch website. The information you add through the website will not be eliminated by a system Replacement report, but the information can be overwritten by a system Replacement. See the ISO ClaimSearch Web User Manual for CMS Reporting version 2.0 for more information on updating claims via the ISO ClaimSearch website.

Converting Legacy Claims to Universal Format

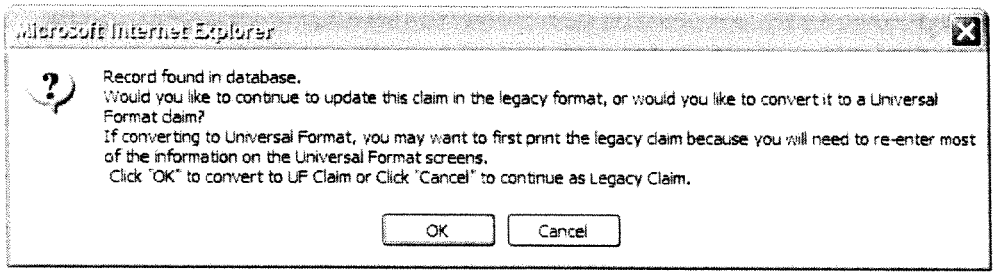
Companies that intend to have ISO ClaimSearch act as their Agent for CMS reporting must report to ISO ClaimSearch in Universal Format.

Companies that report their casualty claims in legacy format either through an automated feed or through the website must convert to Universal Format for CMS reporting. The ISO ClaimSearch Database Development group can assist companies in converting to Universal Format via a system-to-system method. You may contact them at claimsearchdatabasedevelopment@iso.com for more information. To convert to Universal Format reporting via the ClaimSearch website, please contact ISO Customer Service at (800) 888-4476.

ISO ClaimSearch participants that have already converted to Universal Format may still have historical legacy claims on the database. Those claimants may need to be reported to CMS if the claimant is a Medicare recipient.

System-to-system companies can convert legacy claims to Universal Format by submitting the claims as new Universal Format Initial claims with the Legacy Claim Conversion indicator set. All legacy claims that can be located in the ISO ClaimSearch system based on the key fields (customer code, claim number, policy number, date of loss and claimant name) will be deleted and replaced with a Universal Format claim. NOTE: All key fields must be identical to the original claim including the spelling of the claimant's name. Please refer to the "Transitioning from Legacy System Reporting" section of either the Universal Format Manual or the XML Manual for details regarding converting legacy claims to Universal Format through your automated feed.

Companies reporting via the ISO ClaimSearch website can now convert previously reported legacy claims to Universal Format. When the user retrieves a legacy claim, it will give the user the option to update the claim via the legacy format or to convert the claim to Universal Format. See below:



If the user chooses to convert to Universal Format, they will be brought to the Universal Format screens to re-enter the claim. It is important to note that you should print the legacy claim prior to choosing 'OK' so you will have the information needed to enter the data into the Universal Format screens. The legacy claim will be deleted upon submission of the new Universal Format claim. Please refer to the "Updating a Previously Reported Legacy Claim" section of the CMS Web User Guide version 2.0 for more information.

NOTE: *If your company uses a legacy system-to-system interface, the Supplements or Re-Indexes you submit for claims that have been converted to Universal Format will reject. Once a claim has been converted, you must submit changes to converted claims, such as Replacements and Researches, through Universal Format.*

NOTE: *For non-insurers who pay a transactional ISO ClaimSearch fee, please note that every time a claim is converted to Universal Format a new search is performed and thus a charge is generated, just as any time you replace a claim to add additional information, a search is performed and a charge is generated. The charge would be at the Universal Format rate which may not be the same fee as the legacy fee. (For pricing information, please contact your ISO ClaimSearch Account Executive). If a customer chooses to not have a search performed, they must check the 'Submit Claim Only – DO NOT Search' check-box at the bottom of the BASIC INFORMATION page on the web or the 'No Search Indicator' for system-to-system companies. If this indicator is sent, no ISO ClaimSearch match reports will be generated, and no CMS warning messages will be generated.*

ACKNOWLEDGEMENT AND REJECTION SERVICE OVERVIEW

Claims will be sent to CMS on a quarterly basis based on each RRE's assigned reporting period. Within 45 days, CMS will process the claims and will either accept or reject the claims. When ISO receives the results from CMS, ISO will convert the CMS results into separate acknowledgement and reject files per RRE and will post the results of that file on the Account Management section of the ISO ClaimSearch website. Authorized users can log in to download the files of accepted claims and/or rejected claims. Only users with access to this specific file will be able to log in. To obtain access for users, please complete the Authorization Forms provided in your ISO registration package. ISO will send an e-mail to the RRE's Account Manager informing them that the file has been posted.

ISO will link the acknowledgements and rejections to existing claim numbers, ISO file numbers and reporting codes in ISO ClaimSearch to help companies locate their claims in the database.

Users can update and resubmit the rejected claims to ISO ClaimSearch. The system will resubmit the claim to CMS during the next quarterly reporting period.

Below is what the Account Management screen looks like:

ISO ClaimSearch CMS Reports

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For reports questions, please call 201-469-3159, or send an e-mail to cmsreports@iso.com

RRE Code: 123456789 - Report Type: Errors and Ack.

Process

RRE # 123456789 - DESCRIPTION OF RRE CODE

Acknowledgement Reports

Date	Excel File	TEXT File	Download
03/31/2009	Ack_123456789_03312009.csv	Ack_123456789_03312009.txt	☐
12/31/2008	Ack_123456789_12312008.csv	Ack_123456789_12312008.txt	☐
09/30/2008	Ack_123456789_09302008.csv	Ack_123456789_09302009.txt	Processing
06/30/2008	Ack_123456789_06302008.csv	Ack_123456789_06302008.txt	
03/31/2008	Ack_123456789_03312008.csv	Ack_123456789_03312008.txt	
12/31/2007	Ack_123456789_12312007.csv	Ack_123456789_12312007.txt	
09/30/2007	Ack_123456789_09302007.csv	Ack_123456789_09302007.txt	
06/30/2007	Ack_123456789_06302007.csv	Ack_123456789_06302007.txt	

Error Reports

Date	Excel File	TEXT File	Download
03/31/2009	Error_123456789_01312009.csv	Error_123456789_03312009.txt	☐
12/31/2008	Error_123456789_12312009.csv	Error_123456789_12312009.txt	☐
09/30/2008	Error_123456789_09302009.csv	Error_123456789_09302009.txt	
06/30/2008	Error_123456789_06302008.csv	Error_123456789_06302008.txt	
03/31/2008	Error_123456789_03312008.csv	Error_123456789_03312008.txt	
12/31/2007	Error_123456789_12312007.csv	Error_123456789_12312007.txt	
09/30/2007	Error_123456789_09302007.csv	Error_123456789_09302007.txt	

Users with access to download files for multiple RREs will see a drop down where they may select the RRE code for the file they wish to download. There will be a drop-down for a user to choose whether

they are selecting the quarterly Error and Acknowledgement files or the monthly Query Result Files. Customers may choose to download either the Excel File or the Text File.

When you click on the link, the files will be in a .zip file and when you extract the file, it will be either a .csv or .txt file.

Files will remain on the website for two years.

Below are the file names of the acknowledgement and rejection files that will be posted to the Account Management page of the ISO ClaimSearch website.

Acknowledgement

1. Zip file name (csv)– Ack_<RRECode>_<date (MMDDYYYY)>_csv.zip
2. CSV file name – Ack_<RRECode>_<date (MMDDYYYY)>.csv
3. Zip file name (txt)– Ack_<RRECode>_<date (MMDDYYYY)>_txt.zip
4. TXT file name - Ack_<RRECode>_<date (MMDDYYYY)>.txt

Examples:

Ack_999999999_10162009_csv.zip

Ack_999999999_10162009.csv

Ack_999999999_10162009_txt.zip

Ack_999999999_10162009.txt

Error

1. Zip file name (csv)– Error_<RRECode>_<date (MMDDYYYY)>_csv.zip
2. CSV file name – Error_<RRECode>_<date (MMDDYYYY)>.csv
3. Zip file name (txt)– Error_<RRECode>_<date (MMDDYYYY)>_txt.zip
4. TXT file name - Error_<RRECode>_<date (MMDDYYYY)>.txt

Examples:

Error_999999999_10162009_csv.zip

Error_999999999_10162009.csv

Error_999999999_10162009_txt.zip

Error_999999999_10162009.txt

NOTE: *Companies have asked if the file download process can be automated. Currently, an actual user must log into the site to download the file. ISO will consider a future enhancement to return the quarterly result files via FTP.*

The file will be posted in a text file format as well as an Excel format. See Appendix B for the layout of the quarterly result files.

Severe Errors/Threshold Errors

CMS has indicated that if an entire file contains a certain percentage of errors, the entire file will be suspended from processing. The RRE's Account Manager will be notified by CMS via e-mail. Please note that ISO will not be informed by CMS that your file has failed; only your Account Manager will be notified. It would be helpful if you would forward a copy of the e-mail regarding threshold errors to mspreporting@iso.com.

When you receive a threshold error, in most instances, we recommend that you contact your CMS EDI Representative and ask to have the file released for processing. This is the only way you will know exactly which claims rejected for which reasons. Once CMS releases the file, it will take up to 45 days for CMS to process the file. After the file has been processed, ISO will automatically retrieve the results and will post the Acknowledgment and Error file to the Account Management page of the ClaimSearch web site. At that time, you should make any corrections to rejected claims prior to your next quarterly reporting period.

ISO does not expect Severe Errors to occur, but if they do, you should contact ISO at MSPreporting@iso.com as well as your CMS assigned EDI Rep to resolve the situation. Severe errors occur if the file to CMS is not formatted properly or doesn't contain the required records or record counts.

Threshold errors may occur for several reasons. The most likely reason would be that more than 20% of your claims were in error, probably because of missing required fields or the file contained more than 5% delete records. If you receive threshold errors and your files are not processed, please contact ISO at MSPreporting@iso.com so we can work with you and your CMS assigned EDI Representative to determine the appropriate resolution. ***NOTE:*** *If your company does not want claims sent to CMS that you know are missing required fields, you can mark the 'Do not send this party to CMS' or 'Do not send this coverage to CMS' indicator until you obtain the fields necessary for reporting.*

Disposition and Compliance Codes

Below is a list of the disposition and compliance codes which will be returned by CMS. Claims with accepted disposition codes will be returned in the acknowledgement file and claims with rejected disposition codes will be returned in the error file.

DISPOSITION CODES

01 – Record Accepted for Individual Identified as a Medicare Beneficiary and ORM
ISO will return these claims in the acknowledgement file. For ORM claims, ISO will continually check to see if you've updated your claim with any important CMS fields and, if so, we will send updated records to CMS. We will send an update if you've added or changed the ICD9 Codes, TIN, TPOC dates, TPOC Amounts, Claimant 1 Information, or ORM Termination Date. If you've changed any key fields (injured party SSN, CMS Date of Incident, Plan Insurance Type, ORM

Indicator), ISO will automatically detect this and will send a DELETE record followed by a new ADD record. After your claims receive a disposition of "01," if you realize the claim was sent to CMS in error, you can send a "DELETE THIS PARTY FROM CMS" indicator.

02 – Record Accepted for Individual Identified as a Medicare Beneficiary and No ORM
ISO will return these claims in the acknowledgement file. ISO will continually check to see if you've updated your claim with any important CMS fields and, if so, we will send updated records to CMS. We will send an update if you've added or changed the ICD9 Codes, TIN, TPOC dates, TPOC Amounts, Claimant 1 Information. If you've changed any key fields (injured party SSN, CMS Date of Incident, Plan Insurance Type, ORM Indicator), ISO will automatically detect this and will send a DELETE transaction followed by a new ADD record. After your claims receive a disposition of "02," if you realize the claim was sent to CMS in error, you can send a "DELETE THIS PARTY FROM CMS" indicator.

SP – Record in Error
ISO will return these claims on the error file. *ACTION ITEM:* You must make the necessary corrections to your claim by sending an update or replacement to ISO ClaimSearch. When you do so, make sure you don't receive any Warning messages on your match report. A Warning message will not stop us from trying to send your claim to CMS again. ISO will recognize that you made a change to your claim and will try to re-send it in the next quarterly reporting period. We don't check to see what you've changed; only that you've updated/replaced your claim, so if you didn't make any/all of the necessary corrections, the claim will fail again.

51 – Injured Party Not Identified as a Medicare Beneficiary
These aren't truly errors because they don't count toward the 20% error threshold; however, ISO will return these claims on the error file because action is required by you. *ACTION ITEM:* You should update or replace the claim to remove the Medicare eligible indicator = YES. ISO will then begin to query these claims for you again to alert you know if the person becomes eligible in the future. If you learned that the person was eligible through the query process and properly updated the claimant in the database, there is no reason you should receive this error.
*** NOTE: CMS used different criteria prior to November 2010 to determine eligibility than they are using now. It is possible that a query file prior to November 2010 may have indicated that a person is Medicare eligible, but now a Disposition 51 is being returned saying that the person is not eligible. In this instance, CMS recommends beginning the query process again. To do so, remove the Medicare eligible indicator from the claim. ***

03 – Record Accepted for Individual Identified as a Medicare Beneficiary but Outside Medicare Coverage Period
ISO will return these claims on the acknowledgement file. Although CMS says that it "accepted" these records, the records are not actually being saved in its system. These are claims where the injured party is a beneficiary, but the Medicare coverage dates are outside the time period between the date of incident and TPOC or ORM Termination date. If you have ORM for these claims, you must continue to monitor the status of the injury. For ORM claims, ISO will continue to submit new ADD records on subsequent quarterly claim input files until we no longer receive an "03" disposition or until the ORM Termination Date is reported.

50 – The COBC did not finish processing the record in time to produce a response record within the 45-day turnaround.

This should happen only in rare circumstances. ISO will return these in the error file. You do not need to do anything. ISO will automatically re-submit your claim during the next quarterly reporting period.

ERROR CODE

SP31 – Record submitted prior to effective date of Medicare entitlement.
You do not need to do anything. ISO will automatically re-submit your claim during the next quarterly reporting period.

SP32 – Miscellaneous error.
You do not need to do anything. ISO will automatically re-submit your claim during the next quarterly reporting period.

SP50 – Record is locked by the COBC.
You do not need to do anything. CMS does not want any resubmissions of this record. ISO will not resubmit this record or any changes to this claim to CMS.

TN99 – TIN/Office Code error
ISO will monitor the TIN Reference Response File and will contact you if the errors cannot be corrected by ISO.

COMPLIANCE CODES

Compliance Codes 01 & 03
These compliance codes inform you of late submissions. No action needs to be taken.

Compliance Code 02
This compliance code is sent if the TIN in the TIN Reference File couldn't be validated by the COBC. If you receive this code, please contact ISO since ISO builds the TIN Reference File for you. You may not have provided ISO with the correct TIN to use for your company.
NOTE: *This code is obsolete after 10/1/11.*

Compliance Codes 04 through 09
These compliance codes are sent when invalid TIN/Office Code Addresses are sent on the TIN Reference File Detail Record. Codes are provided for invalid Mailing Address Line 1 (code 04), invalid Mailing Address Line 2 (code 05), Invalid City (Code 06), Invalid State (Code 07), Invalid Zip Code (08) and Invalid Foreign Address (Code 09). See the CMS ALERT: TIN Reference File Address Validation Information dated November 18, 2010 for more information.
NOTE: *These codes are obsolete after 10/1/11.*

TIN REFERENCE RESPONSE FILE

As noted in an Alert posted by CMS dated 4/1/11, effective October 1, 2011, CMS will begin posting a new TIN Reference Response File for every TIN Reference File submitted. CMS will begin editing the addresses associated with your SITE IDs using postal software to ensure that an address is actually deliverable. If any of the addresses do not pass CMS' validation, an error code will be returned in this new file.

ISO currently sends a TIN reference file with every quarterly file submitted on your behalf. In order to save you work time, ISO plans to retrieve these new files and internally monitor the files for errors. You will not be required to make changes to retrieve or react to the additional files. If any of the addresses associated with your SITE IDs reject, you will receive Error Code TN99 in your current CMS Rejection file on the Account Management page of the ISO ClaimSearch website; you do not need to do anything with these errors. The detailed error code will be sent in the new TIN Reference Response File, which ISO will retrieve and monitor. ISO will attempt to diagnose the problem and will contact you if changes need to be made to the addresses you selected to be associated with your SITE IDs in ISO's membership database. ISO will then re-submit a corrected TIN reference file to CMS on your behalf.

No changes to your set up should be required for you to meet the new CMS requirements. ISO will monitor any problems related to invalid SITE ID addresses on TIN Reference Files and will contact your Account Manager if changes are needed.

ISO ClaimSearch MSP Account Management

ISO developed management reports to assist companies in verifying the accuracy of the data provided to ClaimSearch for Medicare Secondary Payer reporting. These management reports will help ensure that the proper individuals are identified as Medicare recipients, that the required data elements are populated on the claims and the proper of volume of claims are reported to CMS.

The reports are accessible on the Account Management page of the ClaimSearch website under CMS Section 111 Management Reports for users who have been designated with access. If you have additional users requiring access, please contact njsupport@iso.com.

Medicare Eligible Report

This report identifies all the claimants that the company has marked as "Medicare eligible" within ClaimSearch for a given month. This report ensures that systems are transmitting the required data in order for claimants to be identified as Medicare recipients and/or that users are updating the claims on the ClaimSearch website with the "Medicare eligible" indicator. Below is a screenshot of the report:

ISO Claimsearch CMS Medicare Eligible Claimants Report

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For questions on the reports, please call 800-888-4476, or send an e-mail to Claimsearchmsp@iso.com

RRE Code: 711111111 **For:** Dec 2010 **Report Type:** Medicare Eligible Claimants

RRE # 711111111 - 1 2 >>

Office Code	Claim Number	Policy Number	Date Of Loss	Claimant Name
Z99500001	1234	1234	10/25/2010	MACK,MARY
Z99500001	121212	121212	11/17/2010	PAYKIN,BORIS

The report provides an RRE Code drop-down if you have access to view the report for more than one RRE.

The first report available dated November 2010 is a cumulative report containing all claimants who were marked as Medicare eligible = yes through the end of November. Each report thereafter only contains the claims that were marked as Medicare eligible that month.

Please note that all claimants on this list will NOT automatically be reported to CMS. The claims will not be sent to CMS if you have marked the indicator on a type of claim or party who is not reportable to CMS, or if you have marked the "Do Not Send to CMS" indicator, or if it is a TPOC claim and the TPOC date has not been provided yet.

Active Warnings Report:

This report will provide users with access to any claims that contain the ISO ClaimSearch CMS Warnings. This is a live report and is generated at the time it is requested. For this reason, it may take a few minutes for the report to be generated. This report will give RREs the ability to see for which claimants they have marked as Medicare eligible, but have missing CMS required fields in order for the companies to update claims to ensure they won't reject from CMS. Below are screenshots of the report:

ISO Claimsearch CMS Active Warning Report

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For questions on the reports, please call 800-888-4476, or send an e-mail to Claimsearchmsp@iso.com

RRE Code: 744444444 **Report Type:** Active Warning

RRE # 744444444 -

Office Code	Claim Number	Policy Number	Date Of Loss	Claimant Name	Details
Z99500001	TEST3	TEST3	06/18/2010	GWSGFLDFJ,EFJLSKDFJSKLD	View
Z99500001	TESTCLM89	TESTCLM89	12/12/2008	CCB,CVBCVBCVB	View
Z99500001	TESTCLM89	TESTCLM89	12/12/2008	BCVB,CVBCVB	View
Z99500001	TEST1	TEST1	06/18/2010	WEUWEO,RGJERJGOPRGT	View
Z99500001	TEST4	TEST4	06/18/2010	EFKLJSDLFKJ,LFJLSKFJSKLJ	View
Z99500001	TEST5	TEST5	06/18/2010	TRETER,TYQREWER	View
Z99500001	TEST2	TEST2	06/18/2010	TRWETWET,ERTYRTWE	View

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The report provides an RRE Code drop-down if you have access to view the report for more than one RRE.

To see the details showing which warnings exist on each claim, click on "View" and you will see this screen. Each claim can have multiple warnings.

CMS Warning Detail Report

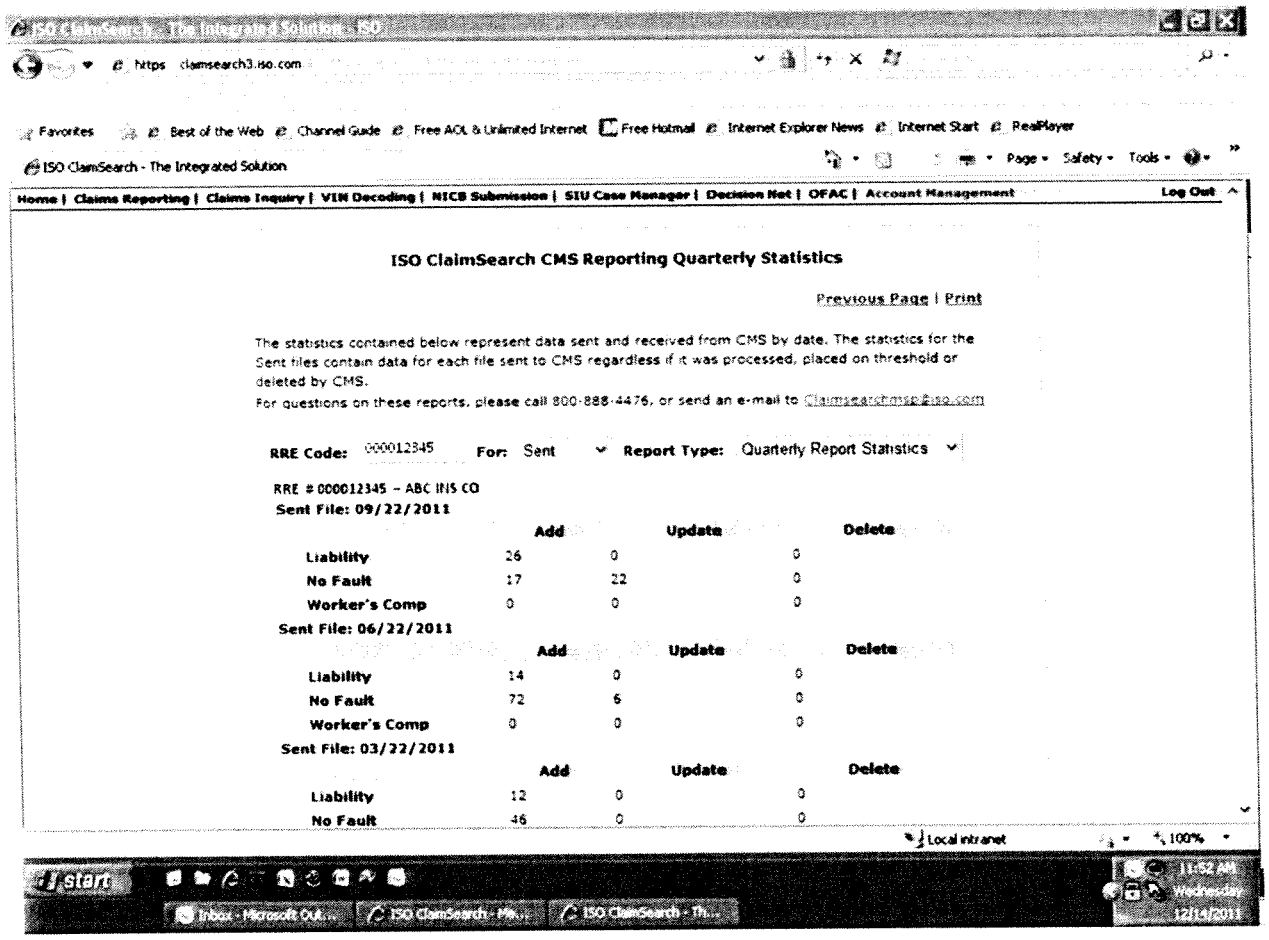
RRE Code	Office Code	Claim Number	Policy Number	Date of Loss
744444444	Z99500001	TEST2	TEST2	06/18/2010

	Claimant Name	Coverage Type	Loss Type	Do Not Send To CMS	Active Warning
1	TRWETWET,ERTYRTWE	MPAY	BODI		Date of Incident Missing or Invalid
2	TRWETWET,ERTYRTWE	MPAY	BODI		Injured Party DOB missing or Invalid
3	TRWETWET,ERTYRTWE	MPAY	BODI		Injured Party HICN or Injured party SSN is required
4	TRWETWET,ERTYRTWE	MPAY	BODI		No-Fault Insurance Limit Missing or Invalid
5	TRWETWET,ERTYRTWE	MPAY	BODI		ORM Indicator Missing or Invalid
6	TRWETWET,ERTYRTWE	MPAY	BODI		State of Venue Missing or Invalid

Print| Close

Quarterly Reporting Statistics

The Quarterly Reporting Statistics report will enable users to verify that the correct volume of claims are reported to CMS on a quarterly basis. The report is broken down by CMS Plan Type (Liability, No Fault and Workers' Compensation. When the quarterly files are returned, users can view the volume accepted and rejected from CMS. Below is a screenshot of the "Sent File" portion of this report. It will be created quarterly after the quarterly file is sent to CMS.



Home | Claims Reporting | Claims Inquiry | VIN Decoding | NICB Submission | SIU Case Manager | Decision Net | OFAC | Account Management | Log Out

ISO ClaimSearch CMS Reporting Quarterly Statistics

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The statistics contained below represent data sent and received from CMS by date. The statistics for the Sent files contain data for each file sent to CMS regardless if it was processed, placed on threshold or deleted by CMS.
For questions on these reports, please call 800-888-4476, or send an e-mail to Claimsearchmsp@iso.com

RRE Code: 000012345 **For:** Sent **Report Type:** Quarterly Report Statistics

RRE # 000012345 – ABC INS CO

Sent File: 09/22/2011

	Add	Update	Delete
Liability	26	0	0
No Fault	17	22	0
Worker's Comp	0	0	0

Sent File: 06/22/2011

	Add	Update	Delete
Liability	14	0	0
No Fault	72	6	0
Worker's Comp	0	0	0

Sent File: 03/22/2011

	Add	Update	Delete
Liability	12	0	0
No Fault	46	0	0

Below is the "Received File" portion of this report. It will remain blank until CMS processes the file and provides the results.

ClaimSearch

Account Management

Home | Claims Reporting | Claims Inquiry | VIN Decoding | NICB Submission | SIU Case Manager | Decision Net | OFAC | Account Management Log Out

ISO ClaimSearch CMS Reporting Quarterly Statistics

Previous Page | Print

The statistics contained below represent data sent and received from CMS by date. The statistics for the Sent files contain data for each file sent to CMS regardless if it was processed, placed on threshold or deleted by CMS.

For questions on these reports, please call 800-888-4476, or send an e-mail to Claimsearchmsp@iso.com

RRE Code: 000012345 **For:** Received **Report Type:** Quarterly Report Statistics

RRE # 000012345 – ABC INS CO

Received File: 10/25/2011

	Accepted			Rejected
	Add	Update	Delete	
Liability	0	0	0	4
No Fault	0	0	0	0
Worker's Comp	0	0	0	0

Received File: 10/12/2011

	Accepted			Rejected
	Add	Update	Delete	
Liability	10	0	4	17
No Fault	13	22	0	4
Worker's Comp	0	0	0	0

Received File: 06/28/2011

	Accepted			Rejected
	Add	Update	Delete	
Liability	12	0	0	2
No Fault	61	5	0	12
Worker's Comp	0	0	0	0

Received File: 03/30/2011

start | Inbox - Microsoft Out... | ISO ClaimSearch - Me... | ISO ClaimSearch - Th... | 11:56 AM Wednesday 12/14/2011

PRIVACY AND SECURITY

ISO ClaimSearch operates in accordance with state and federal privacy legislation. The Gramm-Leach-Bliley Act of 1999 (P.L. 106-102), 15 U.S.C., Section 6801 *et sec.*, and the National Association of Insurance Commissioners' Privacy of Consumer Financial and Health Information Model Regulation ("NAIC Model Rule") and its Insurance Information and Privacy Protection Model Act ("NAIC Model Act") permit the use of the ISO ClaimSearch database for fraud fighting and claims administration purposes.

Please refer to the ISO ClaimSearch and Security Policy for additional information.

Disclosure of Medicare Secondary Payer Information

ISO ClaimSearch participants are authorized to participate in and share personally identifiable information (PII), for the adjustment of claims or the investigation of fraud. ISO ClaimSearch is sensitive to the sharing of possible protected health information (PHI) by non-covered entities. Although ISO's position is that the majority of ISO ClaimSearch data is not considered PHI, ISO will not release data in fields of information added to ISO ClaimSearch specifically for compliance with Medicare Secondary Payer requirements to any party other than the company that enters the information. Data in fields added for Medicare Secondary Payer requirements will not appear in match reports to other ISO ClaimSearch participants. ISO ClaimSearch participants are to use considerable discretion in the disclosure of information filed on ISO ClaimSearch reports, especially in those CMS designated fields returned to the originating reporting organization, both as direct ISO ClaimSearch participants, or third party administrators reporting on behalf of ISO ClaimSearch participants.

TRAINING

ISO has posted documentation and recorded Web-Ex training sessions to the ISO website at www.iso.com/msp as well as to the User Manuals and Guides section on the ClaimSearch website at https://claimsearch.iso.com for users with access. See the AVAILABLE RESOURCES section of this guide for more information. ISO also offers individual company training. If your company is interested in online or in person training (some minimum attendance is required), please contact ISO ClaimSearch Customer Service at (800) 888-4476.

TESTING WITH CMS

ISO completed "pilot testing" with the Coordination of Benefits Contractor (COBC). By completing the pilot, the COBC will automatically move the RREs from Testing Status to Production Status. *If your RRE is currently listed in "testing" status, please contact your CMS EDI Representative and ask to be switched to "production" status.* There is no further testing an RRE is required to perform in order to be in Production Status. If an RRE wishes to conduct further testing on an individual basis, ISO can accommodate this request. Please email ClaimSearchMSP@iso.com with your request.

APPEND-DS

To help your company obtain Social Security numbers for claimants, ISO offers an optional service, Append-DS (Append Data and Search). Append-DS will trigger a public-records search when companies report a claim without an SSN.

The system will:

- retrieve public-records information on the claimant, including Social Security Number (SSN)
- telephone number, age, date of birth, and up to four previous addresses
- search the ISO ClaimSearch database for any matching claims using the SSN
- append the SSN and other new information retrieved from public records to the outgoing ISO ClaimSearch match report

Companies can add the SSN and other public records information to the claim report in the database by filing a replacement report. ISO ClaimSearch will not add the information automatically to the claim, store it in the database, or send it to CMS. It is the participating company's responsibility to update the original claim with any pertinent information retrieved through this service.

Append-DS is available at an additional charge. If you are interested in learning more about this service, please contact us at claimsearch.sales@iso.com.

AVAILABLE RESOURCES

Resources on ISO Website

The following resources are available on the MSP page of the ISO website at www.iso.com/msp:

Technical Information

- Instructions and Resources for Medicare Secondary Payer Reporting Service (PDF)
- View the CMS flow for third-party liability claims (PDF)
- View the CMS flow for PIP, MPAY, and WC Med-only claims (PDF)
- CMS Required Field Warnings Generated by ISO ClaimSearch

General Information

- Deadlines for Medicare Secondary Payer Reporting Service
- View the FAQ about the service (PDF)
- Read our comprehensive overview of the service (6/2/09) (PDF)

Web Seminars

- View a recorded web seminar about the ISO ClaimSearch Medicare Secondary Payer Reporting Service (11/09/09)
- View a PDF of the recorded web seminar about the ISO ClaimSearch Medicare Secondary Payer Reporting service (11/09/09)
- View a slide show on the CMS reporting registration process (6/2/09) (PDF)
- View a PDF of the web seminar (6/9/09) (PDF)
- Listen to a recorded web seminar on MMSEA reporting requirements (9/29/09)

Teleconferences

- April 29

E-mail Blasts and Mailings from ISO

- ICD-9 and External Cause of Injury Codes (11/12/10)
- CMS Alert: Changes to the Timeline for Reporting TPOC Claims (11/9/10)
- Registration, Pre-Query, Updates and Resources (3/12/10)
- Registration, Pre-Query, Updates and Resources (8/18/09)
- Convert legacy claims to Universal Format on the ISO ClaimSearch website (7/15/09)
- Enhanced Universal Format web screens (7/10/09)
- View the registration letter for ISO ClaimSearch casualty participants (6/2/09) (PDF)

Information from the Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS)

- View the CMS website

Resources on ISO ClaimSearch Website

The following information is available on the ISO ClaimSearch website at https://claimsearch.iso.com. Users with IDs can access the information below on the User Manuals & Guides section.

FAQ

ISO ClaimSearch Medicare Secondary Payer Reporting Service FAQ

Testing New CMS Fields

Letter - Companies Testing New CMS Fields
XML manual - version 5.3
Universal Format manual - version 7.3

Layouts for File Returns from CMS

Letter sent with Query Response File Layout, Acknowledgement File Layout, Error File Layout

Training Webinars

Tuesday, June 14, 2011 ISO ClaimSearch MSP Webinar Recording - CMS Webinar Session – ORM and TPOC reporting mapping in ClaimSearch

Tuesday, June 07, 2011 ISO ClaimSearch MSP Webinar Recording - CMS Webinar Session – CMS & ISO Registration Overview

Thursday, June 1, 2011 ISO ClaimSearch MSP Webinar Recording - CMS Webinar Session - Required Field Warning Codes

Tuesday, May 24, 2011 ISO ClaimSearch MSP Webinar Recording - Obtaining Key CMS Data Elements using Append-DS

May 17, 2011 ISO ClaimSeach MSP Webinar Recording - Reviewing and Understanding our CMS Management Reports

May 12, 2011 ISO ClaimSearch MSP Webinar Recording - Reporting ICD-9/Cause of Injury Codes

December 16 ISO ClaimSearch Medicare Secondary Payer Reporting Service User Meeting Webinar Recording

November 24 ISO ClaimSearch Medicare Secondary Payer Reporting Service Training Webinar Recording

July 15 ISO ClaimSearch Medicare Secondary Payer Reporting Service Webinar Recording

July 15 ISO ClaimSearch Medicare Secondary Payer Reporting Service Webinar Recording

July 15 ISO ClaimSearch Medicare Secondary Payer Reporting Service Webinar PowerPoint Presentation

Pre-Query Extract File Information and Layouts

Pre-Query Extract File Information and Layouts

ISO ClaimSearch Medicare Secondary Payer Reporting Service Web Manual

ISO ClaimSearch Medicare Secondary Payer Reporting Service Web Manual

ISO ClaimSearch Medicare Secondary Payer Reporting Service User Guide

ISO ClaimSearch Medicare Secondary Payer Reporting Service User Guide

CMS Disposition and Compliance Codes

CMS Disposition and Compliance Codes

CMS ICD-9 and Cause of Injury Code Lists

ISO provides the codes that have been published by the **World Health Organization (WHO)** and provided by **The Centers for Medicare & Medicaid Services (CMS)** for use with Medicare Secondary Payer Reporting. For your convenience, ISO ClaimSearch has combined all applicable versions from the CMS website into two excel worksheets.

Please Note: CMS requires at least one ICD-9 Diagnosis code and Cause of Injury code for new records submitted on or after 1/1/11. CMS will review the accuracy of ICD-9 codes to injuries provided, so please be sure to verify your selection(s).

CMS ICD-9 Code List
CMS Cause of Injury Code List

Resources Available Through Your ISO Account Executive

- Product Supplement
- Authorization Forms
- Pre-Query Extract Forms
- Information on Append-DS

Contact us at claimsearchsales@iso.com.

Resources Available Through CMS

http://www.cms.hhs.gov/MandatoryInsRep/

WHO TO CONTACT

For more information, e-mail the ISO ClaimSearch Electronic Reporting Office at claimsearchmsp@iso.com or call 1-800-888-4476.

APPENDIX A – CLAIM TYPES FOR QUERY AND REPORTING TO CMS

Policy, Coverage and Loss Determinations in Universal Format for Medicare Secondary Payer Section 111 Reporting

Medicare Secondary Payer Section 111 reporting specifies three types of (plans) coverage:

- No Fault - defined as any policy coverage or self insured retention that responds to payment for medicals. It is not limited to Automobile coverages under PIP or Med Pay, but also premises medical payments coverage under Commercial and Personal package policies. Terminology adopted that responds for medical payments covered is "Ongoing Responsibility for Medicals (ORM).

- Liability - defined as any policy, or risk retention program, that responds to legal or contractual responsibility for an injury caused to a third party, resulting in a settlement, judgment or award. Terminology adopted for these claims is "Total Payment Obligation to the Claimant" (TPOC).

- Workers Compensation - defined as a regulated program by Federal or State legislation to respond for medical payments and indemnification of claimants hurt while in the course and scope of their employment. Terminology adopted by CMS to respond to these claims is either ORM or TPOC (in the event of a settlement), subject to conditions, thresholds and procedures found in the Medicare Secondary Payer Section 111 User Guide (various editions), produced by CMS,

ISO ClaimSearch utilizes the ISO ClaimSearch Universal Format reporting program wherever possible. As participants are required to select policy, coverage and loss for all claims submitted to ClaimSearch, we try to use the same ISO procedures to reduce redundancy and increase efficiency in reporting.

The Appendix A Policy, Coverage and Loss types for CMS reporting follows the same process as reporting to ClaimSearch in Universal Format. We have, based on the claim type selected, identified the report type (ORM or TPOC) through mapping the policy, coverage and loss as submitted. There is no need for you to identify these types independently since ISO derives the type for you.

As a general rule, claims associated with third party bodily injury claims are considered TPOC claims. Medical Payments under PIP, Med Pay or Workers Compensation are considered ORM for CMS reporting purposes. Currently, ISO is handling all WC claims as ORM. ISO ClaimSearch provides the ability to submit TPOC information on a WC settlement, if companies intend to report Workers Compensation settlements in this manner. Any TPOC information entered on a WC claim will be sent to CMS at the designated ORM timeframes.

We have identified the applicable policy, coverage and loss types that are required for CMS Section 111 reporting. We have also identified and explained policy, coverage and loss types that may cause some confusion in their relative definitions. Types requiring further definitions are marked in the chart below with an asterisk (*) and the definition is explained in the Comments column.

NOTE: The ISO ClaimSearch Policy, Coverage and Loss tables are designed to align claims with associated coverage types to assist in the identification of the losses against those submitted by participating companies in match report review. These codes may not include all policy, coverage and loss types, but will include those to respond for CMS Section 111 reporting through ISO ClaimSearch.

On the next page are the Universal Format System-to-System Policy/Coverage/Loss Types, Web Policy/Coverage/Loss Types and Legacy Claim Types which qualify for the Query and Reporting to CMS. Note: Legacy reporting may be used for the CMS query process to identify claimant Medicare eligibility but will not be accepted for reporting to CMS Section 111. Universal Format is required for Section 111 reporting.

Often more than one coverage and loss type will be appropriate for reporting to ISO ClaimSearch and CMS Section 111 reporting. These coverages may represent both a Liability claim (TPOC) and a Medical Payments claim (ORM) in the same loss under the same policy. Separate coverages are to be submitted in the event there are both TPOC and ORM claims in the same report.

Universal Format

Commercial Policies						
Policy	**Coverage**	**Loss Type**	**Comments**	**Ongoing Medical (No Fault) (ORM)**	**Liability (TPOC)**	**WC**
CPMP (*) COMMERCIAL MULTI PERIL	**PINJ (*)** (PERSONAL INJURY)	**BODI** (BODILY INJURY)	**(*) CPMP** - Commercial Package policy; includes first and third party coverage. **(*)PINJ** – Personal Injury; not to be confused with Bodily Injury. Includes libel, slander, discrimination , wrongful termination, etc...		X	
		OTCA (OTHER CASUALTY)	(*) OTCA should be entered for other casualty bodily injury claims		X	
		OTPI (*) (OTHER PERSONAL INJURY)	**(*) OTPI** - Personal injury other than bodily injury loss type (may be no bodily injury allegations)		X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
CPMP (*) (continued)		**ENVR** (ENVIRONMENTAL)	Should include only injury claims		X	
		OTCA (OTHER)			X	
	PROD (*) (PRODUCTS & COMPLETED OPERATIONS)	**BODI** (BODILY INJURY)	**(*)PROD** – Product Liability and Completed Operations; coverage can be BODI or Other loss type. Report injury only for CMS.		X	
		OTCA (OTHER)			X	
	PTCI (*) (PROTECTION & INDEMNITY)	**BODI** (BODILY INURY)	**(*)PTCI** – Protection and Indemnity; coverage provided for Marine exposures.		X	
		OTCA (OTHER)			X	
	DRCT (DIRECTORS & OFFICERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	EROM (ERRORS & OMISSIONS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	ERPL (EMPLOYERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)				
	LIAB (*) (LIABILITY)	**BODI (BODILY INJURY)**	(*)LIAB – Liability; third party coverage; bodily or personal injury for CMS reporting.		X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
CPMP (*) (continued)		**DOGB** (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		BISF (SLIP & FALL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	MPAY (*) (MEDICAL PAYMENTS)	**MPAY** (MEDICAL PAYMENTS)	**(*)MPAY –** Medical Payments; medical payments coverage included in package policies (non-auto).	X		
		BODI (BODILY INJURY)		X		
	OTLB (*) (OTHER LIABILITY)	**BISF** (SLIP & FALL)	**(*)OTLB –** Other Liability; other liability coverage for injury not included above.		X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (*) (MEDICAL PAYMENTS)	(*) MPAY can include medical payments as a basis for liability payment vs. a coverage afforded under the policy.	X		

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
CFRM (FARMOWNERS)	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
CCGL (GENERAL LIABILITY)	**DRCT** (DIRECTORS & OFFICERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	EROM (ERRORS & OMISSIONS)	**BODI (BODILY INJURY)**			X	
		OTCA (OTHER)			X	
	ERPL (EMPLOYERS)	**BODI (BODILY INJURY)**			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
CCGL (continued)		**OTCA** (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	LIAB (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	(*)POLL (POLLUTION)	**BODI** (BODILY INJURY)	(*) should include only injury claims		X	
		ENVR (ENVIRONMENTAL)			X	
		OTCA (OTHER)			X	
	MED PAY	**MPAY** (MEDICAL PAYMENTS)		X		
		BODI (BODILY INJURY		X		

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
	PROD (PRODUCTS & COMPLETED)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
PLIB (PROFESSIONAL LIABILITY)	**DRCT** (DIRECTORS & OFFICERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	EROM (ERRORS & OMMISIONS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	ERPL (EMPLOYERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	LIAB (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTPI (OTHER PERSONAL INJURY			X	
		OTCA (OTHER)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI (BODILY INJURY)**		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF (SLIP & FALL)**			X	
		BODI (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
PLIB (continued)		**DOGB** (DOG BITE)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
MMAL (*) (MEDICAL MALPRACTICE)	**OTLB** (OTHER LIABILITY)	**BISF** (SLIP & FALL)	**(*)MMAL** – Medical Malpractice; Liability claims under Med Mal policies.		X	
		BODI (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		MPAY (MEDICAL PAYMENT		X		
COMR (*) (OCEAN MARINE)	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)	**(*)COMR** – Commercial Ocean Marine; Commercial Marine policies; includes all liability coverages for CMS reporting.		X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER CASUALTY)			X	
	PTCI (PROTECTION & INDEMNITY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER CASUALTY)			X	
OLIB (*) (OTHER LIABILITY)	**DRCT** (DIRECTORS & OFFICERS)	**BODI** (BODILY INJURY)	**(*)OLIB** – Other Liability; can include liability coverages other than BODI for CMS reporting.		X	
		OTCA (OTHER)			X	
	EROM (ERRORS & OMISSIONS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	ERPL (EMPLOYERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	LIAB (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
		OTCA (OTHER)			X	
	PINJ (PERSONAL INJURY)	**OTPI (OTHER PERSONAL INJURY)**			X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	
		ENVR (ENVIRONMENTAL)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		OTCA (OTHER)			X	
	PROD (PRODUCTS & COMPLETED)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
UMBR (*) (UMBRELLA)	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)	**(*)UMBR** – Umbrella Coverage; specific excess and drop down liability coverage. Report injury only for CMS.		X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER CASUALTY)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER CASUALTY)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
CAVN (COMMERCIAL AVIATION)	LIAB (LIABILITY)	**BISF (SLIP & FALL)**			X	
		BODI (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
CAVN (continued)		**DOGB** (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
CLBO (COMMERCIAL BUSINESS OWNERS)	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	
		ENVR (ENVIRONMENTAL)			X	
		OTCA (OTHER)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
CAPP (*) (COMMERCIAL AUTO)	**BODI** (BODILY INJURY)	**BODI** (BODILY INJURY)	**(*)CAPP –** Commercial Auto Policy; policies written on commercial vehicles or personal vehicles used for business purposes; first party or third party.		X	
		MPAY (MEDICAL PAYMENTS)		X		
		NFLT (PIP)		X		
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	
	GGKP (GARAGE-KEEPERS)	**BODI** (BODILY INJURY)			X	
		OTAU (OTHER AUTO)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI (BODILY INJURY)**		X		

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		MPAY (MEDICAL PAYMENTS)		X		
		OTAU (OTHER AUTO)		X		
		TRSM (TERRORISM)		X		
	NFLT (PIP)	**NFLT** (PIP)		X		
		OTAU (OTHER AUTO)		X		
		BODI (BODILY INJURY)		X		
	OTAU (*) (OTHER AUTO)	**BODI** (BODILY INJURY)	**(*)OTAU –** Other Auto; can be used for non-owned auto coverage, or any Auto coverage not included in other coverage types.		X	
		MPAY (MEDICAL PAYMENTS)		X		
		NFLT (PIP)		X		
		OTAU (OTHER)			X	
		TRSM (TERRORISM)			X	
	UNDR (UNDER-INSURED MOTORIST)	**BODI** (BODILY INJURY)			X	
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	
	UNIN (UNINSURED MOTORIST)	**BODI** (BODILY INJURY)			X	
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	

Personal Policies

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
PPHO	**LIAB**	**BODI** (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOB BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
PPFM (FARMOWNERS)	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
PPFM (cont.)		**DOGB** (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
PPMH (MOBILE HOME)	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
PPMH (continued)	**LIAB** (LIABILITY)	**OTPI** (OTHER PERSONAL INJURY)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		TRSM (TERRORISM)			X	
		OTCA (OTHER CASUALTY)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
PLMA (*) (PERSONAL LIABILITY MARINE)	**LIAB** (LIABILITY)	**BODI** (BODILY INJURY)	**(*)PLMA** – Personal Liability Marine, for liability and bodily injury under personal marine policies		X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	OTLB (OTHER LIABILITY)	**BODI** (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		ENVR (ENVIRONMENTAL)			X	
		TRSM (TERRORISM)			X	
		MPAY (MEDICAL PAYMENTS)		X		
	PTCI (PROTECTION & INDEMNITY)	**BODI** (BODILY INJURY)			X	
BOAT (BOAT POLICIES)	**LIAB** (LIABILITY)	**BODI** (BODILY INJURY)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
PAPP (*) PERSONAL AUTO)	**BODI** (BODILY INJURY)	**BODI** (BODILY INJURY)	**(*)PAPP** – Personal Auto Policy ; policies written on operation or use of a personal auto, or personal vehicles covered under Personal Auto policies. Includes first party coverage for bodily injury and injury coverage on a third party basis; includes underinsured and uninsured motorist coverage, and No Fault or Med Map coverage based on local jurisdiction.		X	
		MPAY (MEDICAL PAYMENTS)		X		

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		NFLT (PIP)		X		
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	**MPAY (*)** (MEDICAL PAYMENTS)	**(*)MPAY** - Medical Payments coverage; can be Med Pay, no fault or other medical payments.	X		
		BODI (*) (BODILY INJURY)	**(*) BODI** – Bodily Injury; coverage provided for Liability Bodily Injury and Medical Payments coverage.	X		
		NFLT (NO FAULT)		X		
		OTAU (OTHER AUTO)		X		
	NFLT (PIP) (*) (NO FAULT)	**BODI** (BODILY INJURY)	**(*) NFLT** – No Fault coverage; can be PIP or other no fault medical payments coverage.	X		
		NFLT (PIP)		X		
		OTAU (OTHER AUTO)		X		
	OTAU (*) (OTHER AUTO)	**BODI** (BODILY INJURY)	**(*) OTAU** – Other Auto; coverage for non-owned auto, or can be used where other coverage is not included in coverage types.		X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		MPAY (MEDICAL PAYMENTS)		X		
		NFLT (PIP)		X		
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	
	UNDR (UNDER-INSURED MOTORIST)	**BODI** (BODILY INJURY)			X	
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	
	UNIN (UNINSURED MOTORIST)	**BODI** (BODILY INJURY)			X	
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	

Workers Compensation						
Policy	**Coverage**	**Loss Type**	**Comments**	**Ongoing Medical (No Fault) (ORM)**	**Liability (TPOC)**	**WC**
WCEL (*) (WORKERS COMP & EMPLOYERS LIABILITY)	**WCIL** (WORKERS COMP INDEMNITY)	**WCIL** (WORKERS COMP INDEMNITY)	**(*)WCEL –** Workers Comp; all coverages under Workers Compensation, including Employers Liability.			X
	WCLL (WORKERS COMP LIABILITY)	**WCLL** (WORKERS COMP LIABILITY)				X
	WCML (WORKERS COMP MEDICAL)	**WCML** (WORKERS COMP MEDICAL)				X
WCMA (WORKERS COMP MARINE)	**WCIL** (WORKERS COMP INDEMNITY)	**WCIL** (WORKERS COMP INDEMNITY)				X
	WCLL (WORKERS COMP LIABILITY)	**WCLL** (WORKERS COMP LIABILITY)				X
	WCML (WORKERS COMP MEDICAL)	**WCML** (WORKERS COMP MEDICAL)				X

Accident and Health						
Policy	**Coverage**	**Loss Type**	**Comments**	**Ongoing Medical (No Fault) (ORM)**	**Liability (TPOC)**	**WC**
ACHE(*) ACCIDENT AND HEALTH	**DISB(*) DISABILITY**	**DISB**	(*)ACHE – Accident & Health; accident policies written by Property and Casualty insurers. NOTE: Use this policy type for Occupational Injury Claims. (*)DISB – Disability; disability coverage under Accident and Health policies written by Property Casualty coverages. NOTE: Use for Occupational Injury claims.	X		
	HEAL	**HEAL**	Health Claims under Property and Casualty Policies	X		

WEB Universal Format Reporting

In some instances, the ClaimSearch Universal Format website builds different policy/coverage/loss types on the backend than what is normally coded by system-to-system customers. Below are the codes (when different from the codes listed on the chart above) which are created by web entry. ***These codes SHOULD NOT BE PROGRAMMED by system-to-system companies.*** These codes are only being provided for reference purposed if they appear on a Pre-Query extract file for web-reported claims and you need to know the translation of the codes.

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
CLMP COMMERCIAL LIABILITY MULTI PERIL	**DRCT** (DIRECTORS & OFFICERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	EROM (ERRORS & OMISSIONS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	ERPL (EMPLOYERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	LIAB (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRON-MENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRON-MENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER CASUALTY)			X	
		OTPI (*) (OTHER PERSONAL INJURY			X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	
		ENVR (ENVIRON-MENTAL)			X	
		OTCA (OTHER)			X	
	PROD (*)(PRODUCTS & COMPLETED OPERATIONS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	PTCI (PROTECTION & INDEMNITY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
CFRL COMMERCIAL FARM LIABILITY		**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENT AL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	MPAY (MEDICAL PAYMENTS	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)		X		
	OTLB (OTHER LIABILITY)	**BODI** (BODILY INJURY)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
COML COMMERCIAL OCEAN MARINE LIABILITY	**LIAB** (LIABILITY)	**OTCA** (OTHER)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		MPAY (MEDICAL PAYMENTS		X		
		OTCA (OTHER CASUALTY)			X	
	PTCI (PROTECTION & INDEMNITY)	**BODI** (BODILY INJURY)			X	
CAVL COMMERCIAL AVIATION LIABILITY	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
PLMH PERSONAL MOBILE HOME LIABILITY	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRON-MENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		TRSM (TERRORISM)			X	
		OTCA (OTHER CASUALTY)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
PLFM PERSONAL FARM LIABILITY	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY			X	
		DOGB (DOG BITE)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	**MPAY** (MEDICAL PAYMENTS)		X		
		BODI (BODILY INJURY)		X		
	OTLB (OTHER LIABILTIY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRON-MENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	

Legacy Casualty Format

Below are the legacy claim types which qualify for CMS Query and Reporting.

HOL	Homeowners Liability
MP	Homeowners Med Pay
GL	General Liability
WC	Workers Compensation
AUTO	Auto Liability Bodily Injury
AMP	Auto Med Pay
PIP	Auto No Fault
DIS	Disability
N/RPT	Other

APPENDIX B – LAYOUT FOR QUERY RESPONSE FILE

Record NGQR – Non Group Health Query Response File Record

If multiple claims are found in the ISO ClaimSearch database with the same SSN, this record will be repeated for each claim found.

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGQR	Record Identifier	4	A/N	Contains value of "NGQR'
11-40		Claim Number	30	A/N	Claim Number assigned to loss
41-49		Insuring Company Code	9	A/N	The customer ID code assigned by ClaimSearch
50-61		Health Insurance Claim Number (HICN)	12	A/N	Applied Medicare Health Insurance Claim Number.
62-67		Last Name	6	A/N	Applied Surname of Individual/Injured Party. Updated with Medicare information if the individual is identified as a Medicare beneficiary based upon the information submitted.
68		First Initial	1	A/N	Applied First Initial of Individual/Injured Party. Updated with Medicare information if the individual is identified as a Medicare beneficiary based upon the information submitted.
69-76		Date of Birth	8	N	Applied Individual's Date of Birth (YYYYMMDD). Updated with Medicare information if the individual is identified as a Medicare beneficiary based upon the information submitted.
77		Gender	1	N	Applied Covered individual's gender: 0 = unknown 1 = male 2 = female Updated with Medicare information if the individual is identified as a Medicare beneficiary based upon the information submitted.
78-86		SSN	9	N	Social Security Number of the Individual as submitted by the RRE on the input record. Note: If both a HICN and an SSN were submitted on the input file and CMS matched on the HICN, CMS takes no action to validate the SSN. The first 5 positions of the SSN will be masked (zero-filled).
87-97		ISO File Number	11	A/N	Claim Identifier
98-127		Policy Number	30	A/N	Policy Number assigned to loss
128-135		Date of Loss	8	N	YYYYMMDD
136-205		Adjuster Name	70	A/N	
206-275		Insured Name	70	A/N	

Position			Length	Type	Description
276-305		Submitted Claimant Last Name	30	A/N	
306-325		Submitted Claimant First Name	20	A/N	
326-337		Submitted Claimant Middle Name	12	A/N	
338-357		Routing/Miscellaneous Info	20	A/N	
358		Claim Source	1	A/N	L = legacy; U = Universal Format
359		Reported Source	1	A/N	Universal Format system-to-system methods (F = FTP; L = XML, Q = MQ) Legacy system-to-system methods (F = FTP, I = IIN, O = Online, T = Tape, X = Tracs, 3 = 3780) W = Web D = paper (data entry) A = legacy ACE software
360		Filler	241	A/N	Spaces

Record NGQH – Non Group Health Query Response File Header Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGQH	Record Identifier	4	A/N	Contains value of 'NGQH'
11-17		Reporting File Type	7	A/N	Contains value of 'NGHPQRS'
18-26		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
27-34		Date file was sent to CMS	8	N	Date the input file was sent to CMS. Format: YYYYMMDD
35-42		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
43-600		Filler	558	A/N	Spaces

Record NGQT – Non Group Health Query Response File Trailer Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGQT	Record Identifier	4	A/N	Contains value of 'NGQT'
11-19		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
20-27		Date file was sent to CMS	8	N	Date the input file was sent to CMS.

					Format: YYYYMMDD
28-35		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
Position			**Length**	**Type**	**Description**
36-42		File Record Count	7	N	Number of detail response records contained within file (does not include header or trailer records).
43-600		Filler	558	A/N	Spaces

APPENDIX C – LAYOUT FOR ACKNOWLEDGEMENT FILE

RECORD NGRD – Non Group Health Response File Detail Record

Position			Length	Type	Description
INFORMATION PROVIDED BY ISO CLAIMSEARCH					
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGRD	Record Identifier	4	A/N	Contains value of "NGRD'
11-40		Claim Number	30	A/N	Claim Number assigned to loss
41-49		Insuring Company Code	9	A/N	The customer ID code assigned by ClaimSearch
50-64		Document Control Number	15	A/N	The DCN assigned by ISO.
ECHO OF INPUT INFORMATION					
65		Submitted Action Type	1	N	Action performed. 0=Add 1 = Delete 2 = Update/Change
66-77		Submitted Injured Party HICN	12	A/N	Health Insurance Claim Number (HICN) of Injured Party (as supplied on input)
78-86		Submitted Injured Party SSN	9	N	Social Security Number of Injured Party (as supplied on input). The first 5 positions of the SSN will be masked (zero-filled).
87-126		Submitted Injured Party Last Name	40	A/N	As supplied on input record

Position			Length	Type	Description
127-156		Submitted Injured Party First Name	30	A/N	As supplied on input record.
157		Submitted Injured Party Middle Init	1	A/N	As supplied on input record.
158		Submitted Injured Party Gender	1	N	1 = Male 2 = Female 0 = Unknown
159-166		Submitted Injured Party DOB	8	N	Format: YYYYMMDD
167-175		Submitted Plan TIN	9	N	As supplied on input record.
176-184		Submitted Plan Site ID	9	A/N	As supplied on input record.
185-196		Applied Injured Party HICN	12	A/N	Current HICN of Injured Party if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
197-236		Applied Injured Party Last Name	40	A/N	Injured Party Last Name, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
237-266		Applied Injured Party First Name	30	A/N	Injured Party First Name, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
267		Applied Injured Party Middle Initial	1	A/N	Injured Party Middle Initial, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
268		Applied Injured Party Gender	1	A/N	Gender of Injured Party, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied. 1 = Male 2 = Female

Position			Length	Type	Description
269-276		Applied Injured Party DOB	8	N	Date of Birth of Injured Party, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied. Format: YYYYMMDD
277-284		Applied MSP Effective Date	8	N	Applied Medicare Secondary Payer (MSP) effective date, if identified as a Medicare beneficiary based upon the information submitted, and the claim information reflects ORM, the start date of Medicare's secondary payment status for the incident, illness or injury. Will be the later of the beneficiary's Medicare entitlement/eligibility start date or the CMS Date of Incident. This is the effective date of the MSP occurrence posted to the internal Medicare systems which are used in Medicare claim payment determinations. Will contain all zeroes if not applicable. COBC supplied. Format: YYYYMMDD.
285-292		Applied MSP Termination Date	8	N	Applied Medicare Secondary Payer (MSP) termination date, if identified as a Medicare beneficiary based upon the information submitted, the date posted to internal Medicare systems for the termination of responsibility for ongoing medicals as reported by the RRE. Will contain all zeroes if open-ended or not applicable. COBC supplied. Format: YYYYMMDD.
293		Applied MSP Type Indicator	1	A/N	Applied Medicare Secondary Payer (MSP) Type. COBC supplied. D = No-Fault E = Workers' Compensation L = Liability

Position			Length	Type	Description
294-295		Applied Disposition Code	2	A/N	2-digit code indicating how the record was processed. COBC supplied. 01 = Record accepted by the COBC. RRE has indicated ongoing responsibility for medicals. 02 = Record accepted by the COBC. RRE has indicated no ongoing responsibility for medicals. 03 = Record accepted by the COBC. The injured party was identified as a Medicare beneficiary based on the information submitted, but the beneficiary did not have Medicare coverage during the reported time period.
296-297		Applied Compliance Flag 1	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.

Position			Length	Type	Description
298-299		Applied Compliance Flag 2	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.
300-301		Applied Compliance Flag 3	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.

Position			Length	Type	Description
302-303		Applied Compliance Flag 4 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.
304-305		Applied Compliance Flag 5 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.

Position			Length	Type	Description
306-307		Applied Compliance Flag 6 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.
308-309		Applied Compliance Flag 7 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.

Position			Length	Type	Description
310-311		Applied Compliance Flag 8 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.
312-313		Applied Compliance Flag 9 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.

Position			Length	Type	Description
314-315		Applied Compliance Flag 10 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.
316-319		Coverage Type	4	A/N	Coverage Type reported on ClaimSearch claim. NOTE: For Plan D (No Fault) type claims which are combinable when reported to CMS, the Coverage Type reported will not be sent back to you; you will receive a Coverage Type of COMB indicating that the coverage may have been combined.
320-323		Loss Type	4	A/N	Loss Type reported on ClaimSearch claim. NOTE: For Plan D (No Fault) type claims which are combinable when reported to CMS, the Loss Type reported will not be sent back to you; you will receive a Loss Type of COMB indicating that the coverage may have been combined.
324-334		ISO File Number	11	A/N	ISO Claim Identifier
335-364		Policy Number	30	A/N	Policy assigned to loss

Position			Length	Type	Description
365-372		Date of Loss	8	N	YYYYMMDD
373-442		Adjuster Name	70	A/N	
443-512		Insured Name	70	A/N	
513-532		Routing/Misc.	20	A/N	
533-600		Filler	68	A/N	Spaces

Record NGRH – Non Group Health Response File Header Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGRH	Record Identifier	4	A/N	Contains value of 'NGRH'
11-17		Reporting File Type	7	A/N	Contains value of 'NGHPRSP'
18-26		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
27-34		Date file was sent to CMS	8	N	Date the input file was sent to CMS. Format: YYYYMMDD
35-42		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
43-600		Filler	558	A/N	Spaces

Record NGRT – Non Group Health Response File Trailer Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGRT	Record Identifier	4	A/N	Contains value of 'NGRT'
11-19		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
20-27		Date file was sent to CMS	8	N	Date the input file was sent to CMS. Format: YYYYMMDD
28-35		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
36-42		File Record Count	7	N	Number of detail response records contained within file (does not include header or trailer records).
43-600		Filler	558	A/N	Spaces

APPENDIX D – LAYOUT FOR REJECT FILE

Record NGED – Non Group Health Error File Detail Record

Position			Length	Type	Description
INFORMATION PROVIDED BY ISO CLAIMSEARCH					
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGED	Record Identifier	4	A/N	Contains value of 'NGED'.
11-40		Claim Number	30	A/N	Claim Number assigned to loss
41-49		Insuring Company Code	9	A/N	The customer ID code assigned by ClaimSearch
50-64		Document Control Number	15	A/N	The DCN assigned by ISO.
ECHO OF INPUT INFORMATION					
65		Submitted Action Type	1	N	Action performed (as submitted on input) . 0=Add 1 = Delete 2 = Update/Change
66-77		Submitted Injured Party HICN	12	A/N	Health Insurance Claim Number (HICN) of Injured Party (as supplied on input)
78-86		Submitted Injured Party SSN	9	N	Social Security Number of Injured Party (as supplied on input). The first 5 positions of the SSN will be masked (zero-filled).
87-126		Submitted Injured Party Last Name	40	A/N	As supplied on input record
127-156		Submitted Injured Party First Name	30	A/N	As supplied on input record.
157		Submitted Injured Party Middle Init	1	A/N	As supplied on input record.

Position			Length	Type	Description
158		Submitted Injured Party Gender	1	N	1 = Male 2 = Female 0 = Unknown
159-166		Submitted Injured Party DOB	8	N	Format: YYYYMMDD
167-175		Submitted Plan TIN	9	N	As supplied on input record.
176-184		Submitted Plan Site ID	9	A/N	As supplied on input record.
REJECTION INFORMATION FROM COBC					
185-186		Applied Disposition Code	2	A/N	2 digit code indicating how the record was processed. SP = Record not accepted by the COBC due to errors in the data reported. Record returned with at least one error code. Record must be corrected and resubmitted on the next quarterly file submission. 50 = Record still being processed by CMS. Record must be resubmitted on the next quarterly file submission. 51 = Individual was not identified as a Medicare Beneficiary.
187-191		Error Code 1	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
192-196		Error Code 2	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
197-201		Error Code 3	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.

Position			Length	Type	Description
202-206		Error Code 4	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
207-211		Error Code 5	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
212-216		Error Code 6	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
217-221		Error Code 7	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
222-226		Error Code 8	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
227-231		Error Code 9	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
232-236		Error Code 10	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
237-240		Coverage Type	4	A/N	Coverage Type reported on ClaimSearch claim. NOTE: For Plan D (No Fault) type claims which are combinable when reported to CMS, the Coverage Type reported will not be sent back to you; you will receive a Coverage Type of COMB indicating that the coverage may have been combined.
241-244		Loss Type	4	A/N	Loss Type reported on ClaimSearch claim. NOTE: For Plan D (No Fault) type claims which are combinable when reported to CMS, the Loss Type reported will not be sent back to you; you will receive a Loss Type of COMB indicating that the coverage may have been combined.
245-255		ISO File Number	11	A/N	ISO Claim Identifier

Position			Length	Type	Description
256-285		Policy Number	30	A/N	Policy assigned to loss
286-293		Date of Loss	8	N	YYYYMMDD
294-363		Adjuster Name	70	AN	
364-433		Insured Name	70	A/N	
434-453		Routing/Misc.	20	A/N	
454-600		Filler	147	A/N	Spaces

Record NGEH – Non Group Health Error File Header Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGEH	Record Identifier	4	A/N	Contains value of 'NGEH'
11-17		Reporting File Type	7	A/N	Contains value of 'NGHPERR'
18-26		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
27-34		Date file was sent to CMS	8	N	Date the input file was sent to CMS.
35-42		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
43-600		Filler	558	A/N	Spaces

Record NGET – Non Group Health Error File Trailer Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGET	Record Identifier	4	A/N	Contains value of 'NGET'
11-19		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
20-27		Date file was sent to CMS	8	N	Date the input file was sent to CMS
28-35		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
36-42		File Record Count	7	N	Number of detail response records contained within file (does not include header or trailer records).
43-600		Filler	558	A/N	Spaces

Error Codes – For a complete list of error codes, please refer to the CMS User Guide. ISO provides the information below as a resource, however, the CMS User Guide should be the primary source for this information since ISO's manual may not contain all updates provided by CMS.

Error Code	Field	Description
CB01	Detail or Auxiliary Record Identifier	Required. Must be equal to 'NGCD' (Claim Input File Detail Record) or 'NGCE' (Claim Input File Auxiliary Record). 'NGCE' must always follow an 'NGCD' record. If 'NGCE' record submitted, DCN/HICN/SSN/Injured Party First Name/Injured Party Last Name must match values on the 'NGCD' record.
CB02	DCN	Required. Field must contain value greater than spaces. Value on each detail record must be unique within the file submission.
CB03	Action Type	Required. Field must contain a numeric character. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record, 1 = Delete Record, 2 = Update Record.
CB04	Injured Party HICN	Field must contain spaces or alphanumeric characters. No dashes or hyphens allowed.
CB05	Injured Party SSN	Field must contain all spaces or a numeric value. No dashes, hyphens or special characters allowed.
CB06	Injured Party HICN/SSN	A valid Injured Party HICN or Injured Party SSN must be provided.
CB07	Injured Party Last Name	Required. First position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space. Submit as shown on Social Security or Medicare Card.
CB08	Injured Party First Name	Required. Must contain letters or spaces. Submit as shown on Social Security or Medicare Card.
CB09	Injured Party Middle Init	Optional. Field must contain an alphabetic character or space. No other characters allowed.
CB10	Injured Party Gender	Required. Field must contain a numeric character. Field cannot be spaces or alpha characters. Acceptable numeric characters include the following: 0 = Unknown, 1 = Male, 2 = Female.
CB11	Injured Party DOB	Required. Field must be numeric and contain a valid date prior to the current date. Formatted as CCYYMMDD. Field cannot contain spaces, alpha characters or all zeroes.
CI01	CMS Date of Incident	Required. Field must be numeric and a valid date prior to or equal to the current date. Formatted as CCYYMMDD. Field cannot contain spaces, alpha characters or all zeroes.
CI02	Industry Date of Incident	Optional. Edit bypassed if field equal to all zeroes. Field must be numeric and contain a valid date prior to or equal to the current date or equal to zeroes. Formatted as CCYYMMDD.
CI03	Alleged Cause of Injury	Required for Add and Update records (Action Type = 0 or 2) as of 01/01/2011. If field is equal to spaces prior to 01/01/2011 edit bypassed. First position must be 'E'. Field must contain a valid ICD-9-CM 'E' Code after 1/1/2011. May equal to spaces prior to 1/1/2011. Must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not include decimal point.

Error Code	Field	Description
CI04	State of Venue	Required. Must be a valid US Postal state abbreviation (www.usps.com/ncsc/lookups/abbreviations.html), a value of 'US', or a value of 'FC'.
CI05	ICD-9 Diagnosis Code 1	Required for Add and Update records (Action Type = 0 or 2) as of 01/01/2011. May equal spaces prior to 1/1/2011. If field is equal to spaces prior to 01/01/2011 edit bypassed. Must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI06	ICD-9 Diagnosis Code 2	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI07	ICD-9 Diagnosis Code 3	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI08	ICD-9 Diagnosis Code 4	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI09	ICD-9 Diagnosis Code 5	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI10	ICD-9 Diagnosis Code 6	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI11	ICD-9 Diagnosis Code 7	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI12	ICD-9 Diagnosis Code 8	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI13	ICD-9 Diagnosis Code 9	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.

Error Code	Field	Description
CI14	ICD-9 Diagnosis Code 10	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI15	ICD-9 Diagnosis Code 11	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI16	ICD-9 Diagnosis Code 12	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI17	ICD-9 Diagnosis Code 13	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI18	ICD-9 Diagnosis Code 14	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI19	ICD-9 Diagnosis Code 15	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI20	ICD-9 Diagnosis Code 16	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI21	ICD-9 Diagnosis Code 17	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI22	ICD-9 Diagnosis Code 18	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.

Error Code	Field	Description
CI23	ICD-9 Diagnosis Code 19	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI24	Description of Illness/Injury	Required on Add and Update records (Action Type = 0 or 2) if ICD-9-CM Diagnosis Code 1 and Alleged Cause of Injury not both provided and prior to 01/01/2011. If required must contain alphanumeric characters and not equal to spaces.
CI25	ICD-9 Diagnosis and Alleged Cause of Injury	Prior to 01/01/2011, at least a valid ICD-9 Diagnosis Code 1 and a valid Alleged Cause of Injury must be provided or Description of Illness/Injury must be provided. After 12/31/2010, both a valid ICD-9 Diagnosis Code 1 and a valid Alleged Cause of Injury must be provided.
CI26	Product Liability Indicator	Not used.
CI27	Product Generic Name	Not used.
CI28	Product Brand Name	Not used.
CI29	Product Manufacturer	Not used.
CI30	Product Alleged Harm	Not used.
CS01	Self Insured Indicator	Required if Plan Insurance Type equal to 'E' or 'L'. If required, value must be equal to 'Y' or 'N'. If not required (Plan Insurance Type equals 'D') must equal space or 'N'.
CS02	Self Insured Type	Required if Self Insured Indicator equal to 'Y'. If required, value must equal to "I or 'O'. If not required must equal space.
CS03	Policyholder Last Name	Required when Self Insured Type equal to 'I'. If required, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space. Field must be equal to spaces if Self Insured type not equal to 'I'.
CS04	Policyholder First Name	Required when Self Insured Type equal to 'I'. If required must contain letters or spaces. Field must be equal to spaces if Self Insured Type is not equal to 'I'.
CS05	DBA Name	Field must be equal to spaces if Self Insured Type is equal to 'I'. If greater than spaces, field must contain at least 2 alphanumeric characters.
CS06	Legal Name	Field must be equal to spaces if Self Insured Type is equal to 'I'. If greater than spaces, field must contain at least 2 alphanumeric characters.
CS07	DBA/Legal Name	DBA or Legal name must be provided if Self Insured Type is equal to 'O'.
CP01	Plan Insurance Type	Required. Must contain one of the following alpha characters: 'D' = No-Fault, 'E' = Workers' Compensation, 'L' = Liability.
CP02	TIN	Required. Must contain a valid 9-digit IRS-assigned Federal Tax Identification Number or foreign RRE pseudo-TIN. A corresponding TIN record must have been submitted on the TIN Reference File. Must be numeric. Include leading zeroes. Do not include hyphens.

Error Code	Field	Description
CP03	Office Code/Site ID	Optional. Must be equal to spaces or must contain a 9-digit numeric code. Must have a corresponding entry with associated TIN on the TIN Reference File. A record must be submitted on the TIN Reference File for each unique TIN/Office Code combination.
CP04	Policy Number	Required. Must be at least 3 characters in length. Acceptable characters (alpha, numeric, space, comma, & - ' . @ # / ; or :). Cannot be equal to all spaces.
CP05	Claim Number	Required. Must contain alphanumeric values and cannot be equal to spaces.
CP06	Plan Contact Department Name	Optional. Field may contain alphanumeric characters. If field is not used, field must contain spaces.
CP07	Plan Contact Last Name	Optional. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CP08	Plan Contact First Name	Optional. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
CP09	Plan Contact Phone	Optional. Must contain 10-digit numeric value or zeroes if not provided.
CP10	Plan Contact Phone Extension	Optional. Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided.
CP11	No-Fault Insurance Limit	Must contain a numeric value or all zeroes. If Plan Insurance Type is equal to 'D', a value greater than zeroes must be provided. Fill with all 9's if there is no dollar limit. Fill with zeroes if Plan Insurance Type is 'E' or 'L'.
CP12	Exhaust Date for No-Fault Insurance Limit	Must contain zeroes or a valid date. If Plan Insurance Type is equal to an 'E' or 'L', must contain zeroes.
CP13	TIN/Office Code Mailing Name	Required. Field must contain at least 2 alphanumeric characters. If the Insurer's plan name is equal to SUPPLEMENT, SUPPLEMENTAL, INSURER, MISCELLANEOUS, CMS, ATTORNEY, UNKNOWN, NONE, N/A, UN, MISC, NO, BC, BX, BS, BCBX, BLUE CROSS, BLUE SHIELD, or MEDICARE the CP13 error will be applied. Extracted from TIN Reference file.
CP14	TIN/Office Code Mailing Address Line 1	Required. Field must contain alphanumeric characters. Field cannot be blank or equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If TIN/Office Code State is 'FC', must be blank. Extracted from TIN Reference file.

Error Code	Field	Description
CP15	TIN/Office Code Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If TIN/Office Code State is 'FC', must be blank. Extracted from TIN Reference file.
CP16	TIN/Office Code City	Required. Embedded spaces are allowed for multi-word city name. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If TIN/Office Code State is 'FC', must be blank. Extracted from TIN Reference file.
CP17	TIN/Office Code State	Required. Field must contain US Postal Abbreviation Code or 'FC'. See www.usps.com/ncsc/lookups/abbreviations.html. Extracted from TIN Reference file.
CP18	TIN/Office Code Zip	Required. Field must contain a valid 5-digit numeric US Zip Code. If TIN/Office Code State is 'FC', must be blank. Extracted from TIN Reference file.
CP19	TIN/Office Code Zip+4	Field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If TIN/Office Code State is 'FC', must be zeroes. Extracted from TIN Reference file.
CP20	Foreign RRE Address Line 1	If TIN/Office Code State is not 'FC', must be equal to spaces. If TIN/Office Code State is 'FC', must contain at least one non-blank character.
CP21	Foreign RRE Address Line 2	If TIN/Office Code State is not 'FC', must be equal to spaces. If TIN/Office Code State is 'FC', must be blank or valid alphanumeric characters.
CP22	Foreign RRE Address Line 3	If TIN/Office Code State is not 'FC', must be equal to spaces. If TIN/Office Code State is 'FC', must be blank or valid alphanumeric characters.
CP23	Foreign RRE Address Line 4	If TIN/Office Code State is not 'FC', must be equal to spaces. If TIN/Office Code State is 'FC', must be blank or valid alphanumeric characters.
CR01	Injured Party Representative Indicator	Must be an alpha value of: 'A' = Attorney, 'G' = Guardian, 'P' = Power of Attorney, 'O' = Other, Space = None.
CR02	Representative Last Name	If Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR03	Representative First Name	If Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.

Error Code	Field	Description
CR04	Representative Firm Name	If Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR05	Representative TIN	May contain a 9-digit number, all zeroes or all spaces.
CR06	Representative Mailing Address Line 1	Required if Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Representative Indicator is equal to spaces, field must be equal to spaces. If Representative State = 'FC', field must be equal to all spaces.
CR07	Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR08	Representative City	Required if Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Representative State = 'FC', field must be equal to all spaces
CR09	Representative State	If Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Representative Indicator equal to spaces, field must be equal to spaces.
CR10	Representative Mail Zip Code	If Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Representative Indicator equal to spaces, field must be equal to zeroes. If Representative State = 'FC', field must be equal to all zeroes.
CR11	Representative Mail Zip+4	If Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If Representative Indicator equal to spaces, field must be equal to zeroes. If Representative State = 'FC', field must be equal to all zeroes.
CR12	Representative Phone	If Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Representative Indicator equal to spaces, field must be equal to zeroes. If Representative State = 'FC', field must be equal to all zeroes.
CR13	Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Representative Indicator equal to spaces, field must be equal to spaces.
CR14	Representative Name/Firm Name	Either Representative Last Name *and* Representative First Name – or – Representative Firm Name is required, if Representative Indicator is not equal to spaces.

Error Code	Field	Description
CJ01	ORM Indicator	Required. Must contain a value of 'Y' or 'N'.
CJ02	ORM Termination Date	Must contain a valid date or zeroes. Must be all zeroes if ORM Indicator = 'N'. Future dates are allowed.
CJ03	TPOC Date 1	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date). Required if a non-zero TPOC Amount 1 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be zero if TPOC Amount 1 is zero.
CJ04	TPOC Amount 1	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 1 is supplied. Must be zero if TPOC Date 1 is zero.
CJ05	Funding Delayed Beyond TPOC Start Date 1	Must contain a valid date or zeroes.
CJ06	DOI/ORM Termination Date	ORM Termination Date must be at least 30 days after the CMS Date of Incident. Cannot be more than 6 months greater than the file submission date.
CJ07	TPOC Threshold	Total of TPOC Amounts reported on Add record (Action Type = 0) with ORM Indicator = 'N' does not exceed interim reporting threshold.
CC01	Claimant 1 Relationship	Must be an alpha value of: E = Estate, Individual Name, F = Family, Individual Name, O = Other, Individual Name, X = Estate, Entity Name, Y = Family, Entity Name, Z = Other, Entity Name, Space = Not Applicable.
CC02	Claimant 1 TIN	If Claimant 1 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. May contain a 9-digit number, all zeroes or all spaces. Must not match other Claimant TINs.
CC03	Claimant 1 Last Name	If Claimant 1 Relationship equal to space, field must be equal to spaces. If Claimant 1 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CC04	Claimant 1 First Name	If Claimant 1 Relationship equal to space, field must be equal to spaces. . If Claimant 1 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC05	Claimant 1 Middle Initial	Field must be equal to space or an alpha character. If Claimant 1 Relationship equal to space, field must be equal to space.
CC06	Claimant 1 Mailing Address Line 1	Required if Claimant 1 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 1 Relationship is equal to spaces, field must be equal to spaces. If Claimant 1 State = 'FC', field must be equal to all spaces

Error Code	Field	Description
CC07	Claimant 1 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CC08	Claimant 1 City	Required if Claimant 1 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 1 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 1 State = 'FC', field must be equal to all spaces
CC09	Claimant 1 State	If Claimant 1 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 1 Relationship equal to spaces, field must be equal to spaces.
CC10	Claimant 1 Zip	If Claimant 1 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 1 Relationship equal to spaces, field must be equal to zeroes. If Claimant 1 State = 'FC', field must be equal to all zeroes.
CC11	Claimant 1 Zip+4	If Claimant 1 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 1 Relationship equal to spaces, field must be equal to zeroes. If Claimant 1 State = 'FC', field must be equal to all zeroes.
CC12	Claimant 1 Phone	If Claimant 1 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 1 Relationship equal to spaces, field must be equal to zeroes. If Claimant 1 State = 'FC', field must be equal to all zeroes.
CC13	Claimant 1 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 1 Relationship equal to spaces, field must be equal to spaces.
CC14	Claimant 1 Entity/Organization Name	If Claimant 1 Relationship equal to space, field must contain spaces. If Claimant 1 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.
CC21	Claimant 2 Relationship	Must be an alpha value of: E = Estate, Individual Name, F = Family, Individual Name, O = Other, Individual Name, X = Estate, Entity Name, Y = Family, Entity Name, Z = Other, Entity Name, Space = Not Applicable.
CC22	Claimant 2 TIN	If Claimant 2 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. May contain a 9-digit number, all zeroes or all spaces. Must not match other Claimant SSNs.
CC23	Claimant 2 Last Name	If Claimant 2 Relationship equal to space, field must be equal to spaces. If Claimant 2 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.

Error Code	Field	Description
CC24	Claimant 2 First Name	If Claimant 2 Relationship equal to space, field must be equal to spaces. . If Claimant 2 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC25	Claimant 2 Middle Initial	Field must be equal to space or an alpha character. If Claimant 2 Relationship equal to space, field must be equal to space.
CC26	Claimant 2 Mailing Address Line 1	Required if Claimant 2 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 2 Relationship is equal to spaces, field must be equal to spaces. If Claimant 2 State = 'FC', field must be equal to all spaces
CC27	Claimant 2 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CC28	Claimant 2 City	Required if Claimant 2 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 2 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 2 State = 'FC', field must be equal to all spaces
CC29	Claimant 2 State	If Claimant 2 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 2 Relationship equal to spaces, field must be equal to spaces.
CC30	Claimant 2 Zip	If Claimant 2 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 2 Relationship equal to spaces, field must be equal to zeroes. If Claimant 2 State = 'FC', field must be equal to all zeroes.
CC31	Claimant 2 Zip+4	If Claimant 2 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 2 Relationship equal to spaces, field must be equal to zeroes. If Claimant 2 State = 'FC', field must be equal to all zeroes.
CC32	Claimant 2 Phone	If Claimant 2 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 2 Relationship equal to spaces, field must be equal to zeroes. If Claimant 2 State = 'FC', field must be equal to all zeroes.
CC33	Claimant 2 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 2 Relationship equal to spaces, field must be equal to spaces.
CC34	Claimant 2 Entity/Organization Name	If Claimant 2 Relationship equal to space, field must contain spaces. If Claimant 2 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.

Error Code	Field	Description
CC41	Claimant 3 Relationship	Must be an alpha value of: E = Estate, Individual Name, F = Family, Individual Name, O = Other, Individual Name, X = Estate, Entity Name, Y = Family, Entity Name, Z = Other, Entity Name, Space = Not Applicable.
CC42	Claimant 3 TIN	If Claimant 3 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. May contain a 9-digit number, all zeroes or all spaces. Must not match other Claimant TINs.
CC43	Claimant 3 Last Name	If Claimant 3 Relationship equal to space, field must be equal to spaces. If Claimant 3 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CC44	Claimant 3 First Name	If Claimant 3 Relationship equal to space, field must be equal to spaces. . If Claimant 3 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC45	Claimant 3 Middle Initial	Field must be equal to space or an alpha character. f Claimant 3 Relationship equal to space, field must be equal to space.
CC46	Claimant 3 Mailing Address Line 1	Required if Claimant 3 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 3 Relationship is equal to spaces, field must be equal to spaces. If Claimant 3 State = 'FC', field must be equal to all spaces
CC47	Claimant 3 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CC48	Claimant 3 City	Required if Claimant 3 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 3 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 3 State = 'FC', field must be equal to all spaces
CC49	Claimant 3 State	If Claimant 3 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 3 Relationship equal to spaces, field must be equal to spaces.
CC50	Claimant 3 Zip	If Claimant 3 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 3 Relationship equal to spaces, field must be equal to zeroes. If Claimant 3 State = 'FC', field must be equal to all zeroes.
CC51	Claimant 3 Zip+4	If Claimant 3 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 3 Relationship equal to spaces, field must be equal to zeroes. If Claimant 3 State = 'FC', field must be equal to all zeroes.

Error Code	Field	Description
CC52	Claimant 3 Phone	If Claimant 3 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 3 Relationship equal to spaces, field must be equal to zeroes. If Claimant 3 State = 'FC', field must be equal to all zeroes.
CC53	Claimant 3 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 3 Relationship equal to spaces, field must be equal to spaces.
CC54	Claimant 3 Entity/Organization Name	If Claimant 3 Relationship equal to space, field must contain spaces. If Claimant 3 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.
CC61	Claimant 4 Relationship	Must be an alpha value of: E = Estate, Individual Name, F = Family, Individual Name, O = Other, Individual Name, X = Estate, Entity Name, Y = Family, Entity Name, Z = Other, Entity Name, Space = Not Applicable.
CC62	Claimant 4 TIN	If Claimant 4 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. May contain a 9-digit number, all zeroes or all spaces. Must not match other Claimant TINs.
CC63	Claimant 4 Last Name	If Claimant 4 Relationship equal to space, field must be equal to spaces. If Claimant 4 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CC64	Claimant 4 First Name	If Claimant 4 Relationship equal to space, field must be equal to spaces. . If Claimant 4 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC65	Claimant 4 Middle Initial	Field must be equal to space or an alpha character. If Claimant 4 Relationship equal to space, field must be equal to space.
CC66	Claimant 4 Mailing Address Line 1	Required if Claimant 4 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 4 Relationship is equal to spaces, field must be equal to spaces. If Claimant 4 State = 'FC', field must be equal to all spaces
CC67	Claimant 4 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CC68	Claimant 4 City	Required if Claimant 4 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 4 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 4 State = 'FC', field must be equal to all spaces

Error Code	Field	Description
CC69	Claimant 4 State	If Claimant 4 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 4 Relationship equal to spaces, field must be equal to spaces.
CC70	Claimant 4 Zip	If Claimant 4 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 4 Relationship equal to spaces, field must be equal to zeroes. If Claimant 4 State = 'FC', field must be equal to all zeroes.
CC71	Claimant 4 Zip+4	If Claimant 4 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 4 Relationship equal to spaces, field must be equal to zeroes. If Claimant 4 State = 'FC', field must be equal to all zeroes.
CC72	Claimant 4 Phone	If Claimant 4 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 4 Relationship equal to spaces, field must be equal to zeroes. If Claimant 4 State = 'FC', field must be equal to all zeroes.
CC73	Claimant 4 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 4 Relationship equal to spaces, field must be equal to spaces.
CC74	Claimant 4 Entity/Organization Name	If Claimant 4 Relationship equal to space, field must contain spaces. If Claimant 4 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.
CR21	Claimant 1 Representative Indicator	Must be an alpha value of: 'A' = Attorney, 'G' = Guardian, 'P' = Power of Attorney, 'O' = Other, Space = None.
CR22	Claimant 1 Representative Last Name	If C1 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR23	Claimant 1 Representative First Name	If C1 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
CR24	Claimant 1 Representative Firm Name	If C1 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR25	Claimant 1 Representative TIN	May contain a 9-digit number, all zeroes or all spaces.

Error Code	Field	Description
CR26	Claimant 1 Representative Mailing Address 1	Required if C1 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C1 Representative Indicator is equal to spaces, field must be equal to spaces. If C1 Representative State = 'FC', field must be equal to all spaces.
CR27	Claimant 1 Representative Mailing Address 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR28	Claimant 1 Representative Mailing City	Required if C1 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C1 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C1 Representative State = 'FC', field must be equal to all spaces
CR29	Claimant 1 Representative State	If C1 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C1 Representative Indicator equal to spaces, field must be equal to spaces.
CR30	Claimant 1 Representative Zip	If C1 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C1 Representative Indicator equal to spaces, field must be equal to zeroes. If C1 Representative State = 'FC', field must be equal to all zeroes.
CR31	Claimant 1 Representative Zip+4	If C1 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C1 Representative Indicator equal to spaces, field must be equal to zeroes. If C1 Representative State = 'FC', field must be equal to all zeroes.
CR32	Claimant 1 Representative Phone	If C1 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C1 Representative Indicator equal to spaces, field must be equal to zeroes. If C1 Representative State = 'FC', field must be equal to all zeroes.
CR33	Claimant 1 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C1 Representative Indicator equal to spaces, field must be equal to spaces.
CR34	Claimant 1 Representative Name/Firm Name	Either C1 Representative Last Name *and* C1 Representative First Name – or – C1 Representative Firm Name is required if C1 Representative Indicator is not equal to spaces.
CR41	Claimant 2 Representative Indicator	Must be an alpha value of: 'A' = Attorney, 'G' = Guardian, 'P' = Power of Attorney, 'O' = Other, Space = None.

Error Code	Field	Description
CR42	Claimant 2 Representative Last Name	If C2 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR43	Claimant 2 Representative First Name	If C2 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
CR44	Claimant 2 Representative Firm Name	If C2 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR45	Claimant 2 Representative TIN	May contain a 9-digit number, all zeroes or all spaces.
CR46	Claimant 2 Representative Mailing Address Line 1	Required if C2 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C2 Representative Indicator is equal to spaces, field must be equal to spaces. If C2 Representative State = 'FC', field must be equal to all spaces.
CR47	Claimant 2 Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR48	Claimant 2 Representative City	Required if C2 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C2 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C2 Representative State = 'FC', field must be equal to all spaces
CR49	Claimant 2 Representative State	If C2 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C2 Representative Indicator equal to spaces, field must be equal to spaces.
CR50	Claimant 2 Representative Zip	If C2 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C2 Representative Indicator equal to spaces, field must be equal to zeroes. If C2 Representative State = 'FC', field must be equal to all zeroes.
CR51	Claimant 2 Representative Zip+4	If C2 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C2 Representative Indicator equal to spaces, field must be equal to zeroes. If C2 Representative State = 'FC', field must be equal to all zeroes.

Error Code	Field	Description
CR52	Claimant 2 Representative Phone	If C2 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C2 Representative Indicator equal to spaces, field must be equal to zeroes. If C2 Representative State = 'FC', field must be equal to all zeroes.
CR53	Claimant 2 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C2 Representative Indicator equal to spaces, field must be equal to spaces.
CR54	Claimant 2 Representative Name/Firm Name	Either C2 Representative Last Name *and* C2 Representative First Name – or – C2 Representative Firm Name is required if C2 Representative Indicator is not equal to spaces.
CR61	Claimant 3 Representative Indicator	Must be an alpha value of: 'A' = Attorney, 'G' = Guardian, 'P' = Power of Attorney, 'O' = Other, Space = None.
CR62	Claimant 3 Representative Last Name	If C3 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR63	Claimant 3 Representative First Name	If C3 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
CR64	Claimant 3 Representative Firm Name	If C3 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR65	Claimant 3 Representative TIN	May contain a 9-digit number, all zeroes or all spaces.
CR66	Claimant 3 Representative Mailing Address Line 1	Required if C3 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C3 Representative Indicator is equal to spaces, field must be equal to spaces. If C3 Representative State = 'FC', field must be equal to all spaces.
CR67	Claimant 3 Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR68	Claimant 3 Representative City	Required if C3 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C3 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C3 Representative State = 'FC', field must be equal to all spaces

Error Code	Field	Description
CR69	Claimant 3 Representative State	If C3 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C3 Representative Indicator equal to spaces, field must be equal to spaces.
CR70	Claimant 3 Representative Zip	If C3 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C3 Representative Indicator equal to spaces, field must be equal to zeroes. If C3 Representative State = 'FC', field must be equal to all zeroes.
CR71	Claimant 3 Representative Zip+4	If C3 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C3 Representative Indicator equal to spaces, field must be equal to zeroes. If C3 Representative State = 'FC', field must be equal to all zeroes.
CR72	Claimant 3 Representative Phone	If C3 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C3 Representative Indicator equal to spaces, field must be equal to zeroes. If C3 Representative State = 'FC', field must be equal to all zeroes.
CR73	Claimant 3 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C3 Representative Indicator equal to spaces, field must be equal to spaces.
CR74	Claimant 3 Representative Name/Firm Name	Either C3 Representative Last Name *and* C3 Representative First Name – or – C3 Representative Firm Name is required if C3 Representative Indicator is not equal to spaces.
CR81	Claimant 4 Representative Indicator	Must be an alpha value of: 'A' = Attorney, 'G' = Guardian, 'P' = Power of Attorney, 'O' = Other, Space = None.
CR82	Claimant 4 Representative Last Name	If C4 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR83	Claimant 4 Representative First Name	If C4 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
CR84	Claimant 4 Representative Firm Name	If C4 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR85	Claimant 4 Representative TIN	May contain a 9-digit number, all zeroes or all spaces.

Error Code	Field	Description
CR86	Claimant 4 Representative Mailing Address Line 1	Required if C4 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C4 Representative Indicator is equal to spaces, field must be equal to spaces. If C4 Representative State = 'FC', field must be equal to all spaces.
CR87	Claimant 4 Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR88	Claimant 4 Representative City	Required if C4 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C4 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C4 Representative State = 'FC', field must be equal to all spaces
CR89	Claimant 4 Representative State	If C4 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C4 Representative Indicator equal to spaces, field must be equal to spaces.
CR90	Claimant 4 Representative Zip	If C4 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C4 Representative Indicator equal to spaces, field must be equal to zeroes. If C4 Representative State = 'FC', field must be equal to all zeroes.
CR91	Claimant 4 Representative Zip+4	If C4 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C4 Representative Indicator equal to spaces, field must be equal to zeroes. If C4 Representative State = 'FC', field must be equal to all zeroes.
CR92	Claimant 4 Representative Phone	If C4 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C4 Representative Indicator equal to spaces, field must be equal to zeroes. If C4 Representative State = 'FC', field must be equal to all zeroes.
CR93	Claimant 4 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C4 Representative Indicator equal to spaces, field must be equal to spaces.
CR94	Claimant 4 Representative Name/Firm Name	Either C4 Representative Last Name *and* C4 Representative First Name – or – C4 Representative Firm Name is required if C4 Representative Indicator is not equal to spaces.

Error Code	Field	Description
CT01	TPOC Date 2	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date). Required if a non-zero TPOC Amount 2 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be zero if TPOC Amount 2 is zero.
CT02	TPOC Amount 2	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 2 is supplied. Must be zero if TPOC Date 2 is zero.
CT03	Funding Delayed Beyond TPOC Start Date 2	Must contain a valid date or zeroes.
CT11	TPOC Date 3	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date). Required if a non-zero TPOC Amount 3 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be zero if TPOC Amount 3 is zero.
CT12	TPOC Amount 3	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 3 is supplied. Must be zero if TPOC Date 3 is zero.
CT13	Funding Delayed Beyond TPOC Start Date 3	Must contain a valid date or zeroes.
CT21	TPOC Date 4	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date). Required if a non-zero TPOC Amount 4 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be zero if TPOC Amount 4 is zero.
CT22	TPOC Amount 4	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 4 is supplied. Must be zero if TPOC Date 4 is zero.
CT23	Funding Delayed Beyond TPOC Start Date 4	Must contain a valid date or zeroes.
CT31	TPOC Date 5	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date). Required if a non-zero TPOC Amount 5 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be zero if TPOC Amount 5 is zero.
CT32	TPOC Amount 5	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 5 is supplied. Must be zero if TPOC Date 5 is zero.
CT33	Funding Delayed Beyond TPOC Start Date 5	Must contain a valid date or zeroes.

Error Code	Field	Description
SP31	Action Type	Record submitted prior to effective date of Medicare entitlement. Injured Party matched to a Medicare beneficiary. No correction necessary by RRE. Resubmit record in next quarterly file submission.
SP47	Action Type	No previously accepted record can be matched to submitted delete. Delete failed.
SP48	Action Type	No previously accepted record can be matched to submitted delete. Delete failed.
SP49	Action Type	No previously accepted record can be matched to submitted delete. Delete failed.
SP50	Action Type	Transaction attempted to add.update/delete an ORM record locked by the COBC. No changes are accepted via Section 111 reporting. Do NOT attempt to resubmit this record. See Section 12.2
TN99	TIN/Office Code	No matching, valid TIN Reference File Detail Record was found for the TIN/Office Code combination on the Claim Injput File Detail Record. Refer to errors returned on the TIN Reference Response File. Resubmit corrected TIN Reference File record and/or Claim Input File record.

APPENDIX E – ISO REGISTRATION FORMS & INSTRUCTIONS

ISO ClaimSearch®

Medicare Secondary Payer Reporting Access Authorization Form - Instructions
Insurers, Self-Insureds, and PATs

Please use these Instructions when completing the ISO ClaimSearch Secondary Payer Reporting Access Authorization Form. Each number below corresponds with a numbered field on the Access Form.

Page 1 – Complete this page for each Responsible Reporting Entity (RRE) code your company obtains.

1. **Your Company's:** Name, Address, City, State, Zip, Phone, and Fax.
2. **CMS Account Manager:** The CMS account manager selected by your company – Name, Title, and E-mail.
3. **Member Type: Insurer** – Property/Casualty Insurers and Workers Comp I1nsurers
   Self Insured – Self Insurers and companies with self insured retentions

   PAT (Self Insured Pool) – Liability or Workers Compensation Self Insured Pools
4. **Company NAIC Code:** The National Association of Insurance Commissioners (NAIC) Code for your company (5 digits) – for insurers only.
5. **Office Reporting Code:** Your company's ISO ClaimSearch Office Reporting Code. If creating an RRE at the home office level, you will use a 4-character code. If creating an RRE at the office level, you will use a 9-character code.
6. **RRE Code:** A 9-digit Responsible Reporting Entity (RRE) code assigned to your company by CMS. If registering RREs at an office level only, please be sure each office that must report claims to CMS has an RRE code.
7. **RRE Description:** This is optional and used to identify the RRE – for example, line of business, department, claims system, etc.
8. **TIN/EIN:** Your company's Tax ID number included on the CMS registration for the RRE.
9. **Check Yes or No,** to indicate whether you want ISO to be your company's agent for performing monthly query files.
10. **CMS-Assigned Reporting Period:** The group number that is associated with the quarterly reporting period assigned by the CMS Coordination of Benefits Contractor (COBC) during the registration process.

CMS-Assigned Quarterly Reporting Date	1st Month	2nd Month	3rd Month
01 – 07	Group 1	Group 5	Group 9
08 – 14	Group 2	Group 6	Group 10
15 – 21	Group 3	Group 7	Group 11
22 – 28	Group 4	Group 8	Group 12

11. **Electronic Data Interchange Rep**: Name, Phone, and E-mail for the EDI representative assigned to the RRE during the registration process.
12. **Completed by**: Name and Title of the individual completing the form and the Date the form is completed.

Page 2 – Complete this page for each TIN/EIN and Site ID associated with the RRE that your company will report for. At least one Site ID is required. Also complete if your company requires additional office locations (Sites) for correspondence from CMS.

1. **TIN/EIN:** Your company's Tax ID Number included on the CMS registration for the RRE.
2. **RRE Code:** A 9-digit Responsible Reporting Entity (RRE) code assigned by CMS to your company for reporting claims to CMS.
3. **Site ID:** A 9-digit code developed by your company to identify office(s) that will receive correspondence from CMS.
4. **Site Name:** This is used to name the site – for example, line of business, department, claims system, etc. – and the site Address, City, State, and Zip.

Page 3 – Complete this page to provide existing ISO ClaimSearch User IDs for up to four personnel from your company that are authorized to download the monthly Medicare eligibility query results and the quarterly CMS acknowledgement and rejection files. If you need User IDs for new users, please contact ISO ClaimSearch Customer Support at 800-888-4476 or njsupport@iso.com.

1. **Your Company Name**
2. **Your Company's Office Reporting Code**: Your company's ISO ClaimSearch Office Reporting Code (4 characters).
3. **User Name:** The name of the authorized personnel that will have a User ID.
4. **User ID**: The ISO ClaimSearch User ID of your authorized personnel (5 characters).
5. **RRE Code**: The 9 digit RRE Code under which CMS reports will be posted. List the RRE Code(s) that each user will need access to view CMS reports. If there are more RREs for a user, please copy this page as necessary or provide all of the information on this page in a Microsoft® Excel spreadsheet with the additional RREs for the user.

ISO ClaimSearch®

Medicare Secondary Payer Reporting Access Authorization Form
Insurers, Self-Insureds, and PATs

Please complete the information below to set up access to the ISO ClaimSearch® Medicare Secondary Payer Reporting service. Please complete page 2 for each TIN/EIN and Site ID.
Each Responsible Reporting Entity (RRE) must complete this document.

Responsible Reporting Entity Information

1. Company Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

2. CMS Acct. Mgr.: _____

Title: _____ **E-mail:** _____

3. Member Type: ☐ **Insurer** ☐ **Self-Insured** ☐ **PAT (Self-Insured Pool)**

4. Company NAIC Code *(5 digits)* _____

5. Office Reporting Code *(Home Office is 4 characters and Office is 9 characters):* _____

6. RRE Code *(9 digits):* _____ **7. RRE Description:** _____

8. TIN/EIN *(9 digits):* _____

9. ISO will perform our monthly CMS Query File. **Yes** ☐ **No** ☐

10. CMS Assigned Reporting Period *(Group# as provided by CMS):*

1 ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ **11** ☐ **12** ☐

To identify your CMS assigned group number, please use the CMS defined group number that corresponds to the date your company has been designated to submit claims to CMS.

CMS-Assigned Quarterly Reporting Date	1st Month	2nd Month	3rd Month
01 - 07	Group 1	Group 5	Group 9
08 - 14	Group 2	Group 6	Group 10
15 - 21	Group 3	Group 7	Group 11
22 - 28	Group 4	Group 8	Group 12

11. Electronic Data Interchange Rep *(as provided by CMS):* _____

Phone: _____ **E-mail:** _____

12. Completed by Name: _____ **Title:** _____ **Date:** _____

Return form to: ISO ClaimSearch Customer Support at: Fax: 201-748-1472 or claimsearch.sales@iso.com. If you have any questions, please call 800-888-4476.

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ISO ClaimSearch®

Medicare Secondary Payer Reporting Access Authorization Form

Insurers, Self-Insureds, and PATs – Page 2

Please copy this form as necessary to provide Site ID information for each TIN/EIN.
At least one Site ID is required.

Required Information:

1. Company TIN/EIN *(9 digits):* _____ **2. RRE Code** *(9 digits):* _____

(Must be the same code as on page 1)

Site ID Information:

3. Site ID *(9 digits):* _____ **4. Site Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Site ID Information:

3. Site ID *(9 digits):* _____ **4. Site Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Site ID Information:

3. Site ID *(9 digits):* _____ **4. Site Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Return form to: ISO ClaimSearch Customer Support at: Fax: 201-748-1472 or claimsearch.sales@iso.com. If you have any questions, please call 800-888-4476.

ISO ClaimSearch®

Medicare Secondary Payer Reporting Access Authorization Form
Insurers, Self-Insureds, and PATs – Page 3

Provide existing ISO ClaimSearch User IDs for up to four personnel from your company who are authorized to download the monthly Medicare eligibility query results and the quarterly CMS acknowledgement and rejection files. If you need User IDs for new users, please contact ISO ClaimSearch Customer Support at 800-888-4476 or njsupport@iso.com.

1. Company Name: _____

2. Office Reporting Code *(4 characters)*: _____

User ID Information

3. User Name: _____ **4. User ID** *(5 characters)*: _____

5. RRE Code *(9 digits)*: _____ **5. RRE Code** *(9 digits)*: _____

5. RRE Code *(9 digits)*: _____ **5. RRE Code** *(9 digits)*: _____

User ID Information

3. User Name: _____ **4. User ID** *(5 characters)*: _____

5. RRE Code *(9 digits)*: _____ **5. RRE Code** *(9 digits)*: _____

5. RRE Code *(9 digits)*: _____ **5. RRE Code** *(9 digits)*: _____

User ID Information

3. User Name: _____ **4. User ID** *(5 characters)*: _____

5. RRE Code *(9 digits)*: _____ **5. RRE Code** *(9 digits)*: _____

5. RRE Code *(9 digits)*: _____ **5. RRE Code** *(9 digits)*: _____

User ID Information

3. User Name: _____ **4. User ID** *(5 characters)*: _____

5. RRE Code *(9 digits)*: _____ **5. RRE Code** *(9 digits)*: _____

5. RRE Code *(9 digits)*: _____ **5. RRE Code** *(9 digits)*: _____

Return form to: ISO ClaimSearch Customer Support at: Fax: 201-748-1472 or claimsearch.sales@iso.com. If you have any questions, please call 800-888-4476.

ISO ClaimSearch®

Medicare Secondary Payer Reporting Access Authorization Form - Instructions
Third Party Administrators

The Access Authorization Form for third party administrators (TPAs) is in an Excel format. Please contact ISO ClaimSearch Customer Support at 800-888-4476 or claimsearch.sales@iso.com for the form. Please use these Instructions when completing the Access Authorization Form for TPAs.

Third Party Administrator Information

1. **Your Company's:** Name, Address 1, Address 2, City, State, Zip, Phone, Fax, Contact, Contact Title, Contact E-mail.
2. **Your Company's Office Reporting Code:** Your company's ISO ClaimSearch Office Reporting Code (4 characters).
3. **Completed by:** Name and Title of the individual completing the form and the Date the form is completed at your company.

Insurer or Self-Insured Company Information

4. **Company:** Name, Address 1, Address 2, City, State, Zip, Phone, and Fax.
5. **CMS Account Manager:** The CMS account manager selected by the company – Name, Title, and E-mail.
6. **Member Type: Insurer** – Property/Casualty insurers and Workers Comp insurers
   Self Insured – Self Insurers and companies with self insured retentions
   PAT (Self Insured Pool) – Liability or Workers Compensation Self Insured Pools
7. **Company NAIC Code:** The National Association of Insurance Commissioners (NAIC) Code for the company (5 digits) – for insurers only.
8. **Office Reporting Code:** The company's ISO ClaimSearch Office Reporting Code if known. If creating an RRE at the home office level, you will use a 4-character code. If creating an RRE at the office level, you will use a 9-character code.
9. **RRE Code:** A 9-digit Responsible Reporting Entity (RRE) code assigned to the company by CMS. If registering RREs at an office level only, please be sure each office that must report claims to CMS has an RRE code.
10. **RRE Description:** This is optional and used to identify the RRE – for example, line of business, department, claims system, etc.
11. **TIN/EIN:** The company's Tax ID number included on the CMS registration for the RRE.
12. **Will ISO Perform Monthly Query Yes or No:** Enter Y or N to indicate whether you want ISO to be the company's agent for performing monthly query files.
13. **CMS-Assigned Reporting Period:** The group number that is associated with the quarterly reporting period assigned by the CMS Coordination of Benefits Contractor (COBC) during the registration process.

CMS-Assigned Quarterly Reporting Date	1st Month	2nd Month	3rd Month
01 – 07	Group 1	Group 5	Group 9
08 – 14	Group 2	Group 6	Group 10
15 – 21	Group 3	Group 7	Group 11
22 – 28	Group 4	Group 8	Group 12

January 2010

14. **CMS Electronic Data Interchange Rep**: Name, Phone, and E-mail for the EDI representative assigned to the RRE during the registration process.
15. **RRE Code:** A 9-digit Responsible Reporting Entity (RRE) code assigned by CMS to the company for reporting claims to CMS.
16. **Site ID:** A 9-digit code developed by the company to identify office(s) that will receive correspondence from CMS. At least one Site ID is required per TIN.
17. **Site Name:** This is used to name office locations (sites) that will need correspondence from CMS – for example, line of business, department, claims system, etc. Also needed are the Site Address, City, State, and Zip.
18. **User Name:** The name of the authorized personnel that will have a User ID. Maximum of four personnel from your company who are authorized to download the monthly Medicare eligibility query results and the quarterly CMS acknowledgement and rejection files. If you need User IDs for new users, please contact ISO ClaimSearch Customer Support at 800-888-4476 or njsupport@iso.com.
19. **User ID**: The ISO ClaimSearch User ID of your authorized personnel (5 characters) listed in #18 above. If an RRE has multiple User IDs that need access to download the reports, then list the multiple IDs one cell under each other, then start a new line for the next RRE.

APPENDIX F - MAPPING OF ISO UNIVERSAL FORMAT (UF) AND XML FIELDS TO THE CMS DETAIL RECORD LAYOUT

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
CLAIM INPUT FILE HEADER RECORD			
	Will be pre-populated by ISO to default value 'NGCH'	RECORD IDENTIFIER	1
	Will be pre-populated by ISO for each file sent to the COBC.	SECTION 111 REPORTER ID	2
	Will be pre-populated by ISO to default value 'NGHPCLM'	SECTION 111 REPORTING FILE TYPE	3
	Will be pre-populated by ISO with the date the file was transmitted to the COBC.	FILE SUBMISSION DATE	4
	Will be pre-populated with spaces.	RESERVED FOR FUTURE USE.	5
CLAIM INPUT FILE DETAIL RECORD			
RRE CODE UA01 465-473 ClaimsOccurrence/ com.iso_RRECd	If a group/company/office only registers one RRE, the company will provide it once upon registration with ISO and will not need to send this field on input; it will be derived by ISO. If a group/company/office registers more than one RRE, the company will provide the codes upon registration with ISO, but will also need to send this field on each claim so ISO will know which RRE code each claim belongs to. TPAs reporting under their own code always need to populate this field.	This is an ISO requirement; not a CMS requirement.	
	Will be pre-populated by ISO to default value 'NGCD'	RECORD IDENTIFIER	1
	Will be pre-populated by ISO with a unique identifier for each record sent.	DCN	2

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
	Will be pre-populated by ISO. • For ORM claims -will be sent as an "Add" when ISO receives the Medicare Eligible Indicator. • Will be sent as "Update" when the following fields are updated on the claim (CMS Date of Incident, Plan Insurance Type, ORM Indicator, ICD-9 Code, , TIN, TPOC Date, TPOC Amount, Claimant Information fields). • Will be sent as "Delete" and then again as "Add" when key fields change (CMS Date of Incident, Plan Insurance Type and ORM Indicator. • Will be sent as "Update" for the last time when the ORM Termination Date is sent. • For TPOC claims – will be sent as an "Add" when ISO receives both the Medicare Eligible Indicator and 1st TPOC date. • Will be sent as an "Update" when additional TPOCs are added or when there are changes in the TPOC amount. • ClaimSearch has added an indicator in which customers can request the deletion of a claimant from CMS.	ACTION TYPE	3

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
INJURED PARTY HICN UEX1 76-87 ClaimInvestigationAddRq/ com.iso_SIUParty/ com.iso_HICN	Once you are provided with a HICN on a query result file, you must add the HICN to your claim so it can be reported on future submissions to CMS.	INJURED PARTY HICN	4
SSN UO01 93-101 ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxId		INJURED PARTY SSN	5
LAST NAME UO01 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		INJURED PARTY LAST NAME	6
FIRST NAME UO01 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		INJURED PARTY FIRST NAME	7
MIDDLE NAME UO01 64-83 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/OtherGivenName		INJURED PARTY MIDDLE INIT	8
GENDER UO01 92 ClaimsParty/PersonInfo/GenderCd	CMS accepts a gender of "unknown". If no gender is reported, ISO will pass "0" for unknown.	INJURED PARTY GENDER	9
DOB UO01 84-91 ClaimsParty/PersonInfo/BirthDt		INJURED PARTY DOB	10
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	11
CMS DATE OF INCIDENT UEX3 11-18 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_CMSIncidentDt		CMS DATE OF INCIDENT	12
DATE OF LOSS UA01 103-110 ClaimsOccurrence/LossDt		INDUSTRY DATE	13
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	14

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS UEX3 500-504 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_CauseOfInjuryCd (codelistref = "CauseOfInjuryCd")	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. DO NOT REPORT THE DECIMAL CODE IN THIS FIELD. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS	15
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	16
STATE OF VENUE UEX3 19-20 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ Addr/StateProvCd		STATE OF VENUE	17
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	18
ICD-9 CODE 1 UEX3 184-189 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd or UC01 272-277 ClaimsParty/ClaimsInjuredInfo/ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 1	19
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	20
ICD-9 CODE 2 UEX3 190-195 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd or UC01 278-283 ClaimsParty/ClaimsInjuredInfo/ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 2	21
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	22

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 3 UEX3 196-201 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd or UC01 284-289 ClaimsParty/ClaimsInjured Info/ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 3	23
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	24
ICD-9 CODE 4 UEX3 202-207 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd or UC01 290-295 ClaimsParty/ClaimsInjured Info/ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 4	25
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	26
ICD-9 CODE 5 UEX3 208-213 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd or UC01 296-301 ClaimsParty/ClaimsInjured Info/ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 5	27
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	28

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 6 UEX3 214-219 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 6	29
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	30
ICD-9 CODE7 UEX3 220-225 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 7	31
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	32
ICD-9 CODE 8 UEX3 226-231 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 8	33
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	34

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 9 UEX3 232-237 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 9	35
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	36
ICD-9 CODE 10 UEX3 238-243 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 10	37
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	38
ICD-9 CODE 11 UEX3 244-249 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 11	39
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	40

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 12 UEX3 250-255 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 12	41
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	42
ICD-9 CODE 13 UEX3 256-261 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. . Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 13	43
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	44
ICD-9 CODE 14 UEX3 262-267 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 14	45
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	46

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 15 UEX3 268-273 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 15	47
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	48
ICD-9 CODE 16 UEX3 274-279 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. . Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 16	49
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	50
ICD-9 CODE 17 UEX3 280-285 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. . Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 17	51
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	52

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 18 UEX3 286-291 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. . Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 18	53
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	54
ICD-9 CODE 19 UEX3 292-297 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 19	55
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	56
ALLEGED INJURIES/PROPERTY DAMAGE UC01 108-157 ClaimsParty/ClaimsInjuredInfo/ClaimsInjury/InjuryNatureDesc **OR** UEX3 450-499 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/ InjuryNatureDesc	This field will not be sent to CMS after 12/31/10, but you should still populate this field on your ClaimSearch reports because this is still a ClaimSearch required field.	DESCRIPTION OF ILLNESS/INJURY	57
PRODUCT LIABILITY INDICATOR UEX4 11 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo2/ com.iso_ProdLiabInd	This field is currently not being passed to CMS based on a change in CMS requirements.	PRODUCT LIABILITY INDICATOR	58

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
PRODUCT GENERIC NAME UEX4 12-51 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo2/ com.iso_GenName	This field is currently not being passed to CMS based on a change in CMS requirements.	PRODUCT GENERIC NAME	59
PRODUCT BRAND NAME UEX4 52-91 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo2/ com.iso_BrandName	This field is currently not being passed to CMS based on a change in CMS requirements.	PRODUCT BRAND NAME	60
PRODUCT MANUFACTURER UEX4 92-131 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo2/ com.iso_ProdMfr	This field is currently not being passed to CMS based on a change in CMS requirements.	PRODUCT MANUFACTURER	61
PRODUCT ALLEGED HARM UEX4 132-331 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo2/ com.iso_AllegedHarm	This field is currently not being passed to CMS based on a change in CMS requirements.	PRODUCT ALLEGED HARM	62
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	63
SELF-INSURED INDICATOR UA01 464 ClaimsOccurrence/com.iso_SelfInsuredInd	Will be pre-populated by ISO with "Y" for all member types of "Self Insured" or "Self Insured Pool" and with "N" for all P&C member types. TPAs reporting under their own ISO reporting code will need to populate this field. For all no-fault claims, the value will be defaulted to "N".	SELF INSURED INDICATOR	64
	ISO will pre-populate this field with "O" for Other than Individual. For all no-fault claims, the value will be defaulted to space.	SELF-INSURED TYPE	65
	This field is required if Self-Insured Type = I, but since ISO will always send "O," this field is not applicable.	POLICYHOLDER LAST NAME	66
	This field is required if Self-Insured Type = I, but since ISO will always send "O," this field is not applicable.	POLICYHOLDER FIRST NAME	67
	This field is required if Self-Insured Type = O and if Legal Name is not provided. Legal Name will always be provided so this field is not applicable.	DBA NAME	68
INSURED NAME UO01 14-83 ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName	This field is required if Self-Insured Type = O and DBA Name is not provided. ISO will pre-populate with the Insured Name.	LEGAL NAME	69

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	70
	ISO will pre-populate this field based on the policy/coverage/loss fields provided. (See Appendix A for table of mappings)	PLAN INSURANCE TYPE	71
TIN UA01 474-482 ClaimsOccurrence/TaxIdentity/TaxId	If an RRE only registers one TIN, the company will provide it once upon registration with ISO and will not need to send this field on input; it will be derived by ISO. If an RRE registers more than one TIN, the company will provide the TINS upon registration with ISO, but will also need to send this field on each claim so ISO will know which TIN each claim belongs to. TPAs reporting under their own code always need to populate this field.	TIN	72
SITE ID UA01 483-491 ClaimsOccurrence/com.iso_SiteId	If a TIN only registers one SITE ID, the company will provide it once upon registration with ISO and will not need to send this field on input; it will be derived by ISO. If a TIN registers more than one SITE ID, the company will provide the SITE IDs upon registration with ISO, but will also need to send this field on each claim so ISO will know which SITE ID each claim belongs to. TPAs reporting under their own code always need to populate this field. This is a numeric only field.	OFFICE CODE/SITE ID	73
POLICY NUMBER UA01 21-50 Policy/PolicyNumber		POLICY NUMBER	74
CLAIM NUMBER UA01 73-102 ClaimsOccurrence/ItemIdInfo/InsurerId		CLAIM NUMBER	75
	This field is Optional and will not be sent to CMS.	PLAN CONTACT DEPARTMENT NAME	76
	This field is Optional and will not be sent to CMS.	PLAN CONTACT LAST NAME	77
	This field is Optional and will not be sent to CMS.	PLAN CONTACT FIRST NAME	78
	This field is Optional and will not be sent to CMS.	PLAN CONTACT PHONE	79
	This field is Optional and will not be sent to CMS.	PLAN CONTACT PHONE EXTENSION	80
NO FAULT INSURANCE LIMIT UEX3 21-31 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_NFLTLimit	Fill with all 9's if there is no dollar limit. Fill with all 0's for WC or Liability claims.	NO-FAULT INSURANCE LIMIT	81

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
EXHAUST DATE FOR DOLLAR LIMIT FOR NO FAULT INSURANCE UEX3 32-39 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/com.iso_ExhaustDt		EXHAUST DATE FOR DOLLAR LIMIT FOR NO-FAULT INSURANCE	82
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	83
INJURED PARTY'S ATTORNEY OR OTHER REPRESENTATIVE INFORMATION			
ROLE IN THE CLAIM USP1 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd (codelistref="ClaimsPartyRoleCd)	All lawyer roles (Claimant Lawyer -LC, Insured Lawyer- LI, Law Office Manager-LM, Law Office-LO, Paralegal- LR, Lawyer-Other- LW, Lawyer for CMS Claimant - LS) will be mapped to A = Attorney. Guardian-GU will be mapped to G = Guardian/Conservator Power of Attorney-PW will be mapped to P = Power of Attorney. Other-OR will be mapped to O = Other Since CMS will only accept one representative, if more than one representative is reported, ISO will use the following hierarchy: Attorney, Guardian, Power of Attorney, Other. ISO will only send representatives that have all required fields reported.	INJURED PARTY REPRESENTATIVE INDICATOR	84
LAST NAME USP1 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname	If the business is reported as an AKA of the service provider, the AKA record would be sent to CMS as the business.	REPRESENTATIVE LAST NAME	85
FIRST NAME USP1 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName	If the business is reported as an AKA of the service provider, the AKA record would be sent to CMS as the business	REPRESENTATIVE FIRST NAME	86
BUSINESS NAME USP1 14-83 ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName	If the individual name is reported as an AKA of the service provider, the AKA record would be sent to CMS as the individual name.	REPRESENTATIVE FIRM NAME	87
TIN USP1 93-101 for SSN, 102-110 for TIN ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxId		REPRESENTATIVE TIN	88

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ADDRESS INFORMATION LINE 1 USP1 148-197 ClaimsParty/GeneralPartyInfo/Addr/Addr1		REPRESENTATIVE MAILING ADDRESS LINE 1	89
ADDRESS INFORMATION LINE 2 USP1 198-247 ClaimsParty/GeneralPartyInfo/Addr/Addr2		REPRESENTATIVE MAILING ADDRESS LINE 2	90
CITY USP1 248-272 ClaimsParty/GeneralPartyInfo/Addr/City		REPRESENTATIVE CITY	91
STATE USP1 273-274 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd	When reporting to ISO, if the Universal Format country field is "US" or blank, ISO will pass the US state to CMS. If the country field contains anything other than "US" or blank, ISO will pass "FC" for "foreign country" to CMS in the state field.	REPRESENTATIVE STATE	92
POSTAL CODE USP1 275-279 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		REPRESENTATIVE MAIL ZIP CODE	93
POSTAL CODE USP1 280-283 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		REPRESENTATIVE MAIL ZIP + 4	94
BUSINESS TELEPHONE USP1 297-306 ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo/PhoneTypeCd="Phone"CommunicationUseCd="Business"and PhoneNumber		REPRESENTATIVE PHONE	95
	This field is Optional and will not be sent to CMS.	REPRESENTATIVE PHONE EXTENSION	96
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	97
SETTLEMENT, JUDGMENT, AWARD OR OTHER PAYMENT INFORMATION			
ON-GOING RESPONSIBILITY FOR MEDICALS (ORM) INDICATOR UEX3 40 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/com.iso_ORMInd	This field is required on all claims to be sent to CMS even if you do not have on-going responsibility. Enter "Yes" if you do have ORM and "No" if you do not. This field is not used to determine if your claim will be sent to CMS according to the ORM or TPOC rules. ISO uses policy, coverage and loss type to map your claim to ORM or TPOC.	ORM INDICATOR	98

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ON-GOING RESPONSIBILITY FOR MEDICALS (ORM) TERMINATION DATE UEX3 41-48 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_ORMDt		ORM TERMINATION DATE	99
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) DATE 1 UEX3 49-56 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCDt		TPOC DATE	100
TOTAL PAYMENT OBLIGA TION TO THE CLAIMANT (TPOC) AMOUNT 1 UEX3 57-67 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCAmt		TPOC AMOUNT	101
FUNDING DELAYED BEYOND TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) START DATE 1 UEX3 68-75 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCStartDt		FUNDING DELAYED BEYOND TPOC START DATE	102
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	103

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
	CLAIMANT INFORMATION 1		
ROLE IN THE CLAIM UACL 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	ES – Estate, FA – Family Member, OC – Other Claimant. If the Individual fields are used, ISO will map to E (Estate, Individual), F (Family, Individual) or O (Other, Individual) when sending to CMS. If the Business field is used, ISO will map to X (Estate, Entity Name), Y (Family, Entity Name) or Z (Other, Entity Name) when sending to CMS. If an invalid role is reported, ISO will default the role to OC.	CLAIMANT 1 RELATIONSHIP	104
UACL 223-231 for SSN, 232-240 for TIN ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxID	If the Individual fields are used, ISO will send the SSN. If the business field is used, ISO will send the TIN.	CLAIMANT 1 TIN	105
UACL 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		CLAIMANT 1 LAST NAME	106
UACL 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		CLAIMANT 1 FIRST NAME	107
UACL 64-83 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/OtherGivenName		CLAIMANT 1 MIDDLE INITIAL	108
UACL 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		CLAIMANT 1 ENTITY/ORGANIZATION NAME	109
UACL 84-133 ClaimsParty/GeneralPartyInfo/Addr/Addr1		CLAIMANT 1 MAILING ADDRESS LINE 1	110
UACL 134-183 ClaimsParty/GeneralPartyInfo/Addr/Addr2		CLAIMANT 1 MAILING ADDRESS LINE 2	111
UACL184-208 ClaimsParty/GeneralPartyInfo/Addr/City		CLAIMANT 1 CITY	112
UACL 209-210 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		CLAIMANT 1 STATE	113
UACL 211-215 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 1 ZIP	114
UACL 216-219 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 1 ZIP+4	115

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
UACL 241-250 ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		CLAIMANT 1 PHONE	116
	This field is Optional and will not be sent to CMS	CLAIMANT 1 PHONE EXTENSION	117
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	118
CLAIMANT 1 ATTORNEY/OTHER REPRESENTATIVE INFORMATION ***This information will be pulled from the Service Provider Record if the USP1 record follows the UACL record.***			
USP1 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	All lawyer roles (Claimant Lawyer -LC, Insured Lawyer- LI, Law Office Manager-LM, Law Office-LO, Paralegal- LR, Lawyer-Other- LW, Lawyer for CMS Claimant - LS) will be mapped to A = Attorney. Guardian-GU will be mapped to G = Guardian/Conservator Power of Attorney-PW will be mapped to P = Power of Attorney. Other-OR will be mapped to O = Other Since CMS will only accept one representative, if more than one representative is reported, ISO will use the following hierarchy: Attorney, Guardian, Power of Attorney, Other. ISO will only send representatives that have all required fields reported.	CLAIMANT 1 (C1) REPRESENTATIVE INDICATOR	119
USP1 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		C1 REPRESENTATIVE LAST NAME	120
USP1 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		C1 REPRESENTATIVE FIRST NAME	121
USP1 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		C1 REPRESENTATIVE FIRM NAME	122
USP1 93-101 for SSN, 102-110 for TIN. ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxId		C1 REPRESENTATIVE TIN	123
USP1 148-197 ClaimsParty/GeneralPartyInfo/Addr/Addr1		C1 REPRESENTATIVE MAILING ADDRESS 1	124

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
USP1 198-247 ClaimsParty/GeneralPartyInfo/Addr/Addr2		C1 REPRESENTATIVE MAILING ADDRESS 2	125
USP1 248-272 ClaimsParty/GeneralPartyInfo/Addr/City		C1 REPRESENTATIVE CITY	126
USP1 273-274 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		C1 REPRESENTATIVE STATE	127
USP1 275-279 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C1 REPRESENTATIVE ZIP	128
USP1 280-283 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C1 REPRESENTATIVE ZIP+4	129
USP1 287-296 if Individual, 297-306 if Business ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		C1 REPRESENTATIVE PHONE	130
	This field is Optional and will not be sent to CMS	C1 REPRESENTATIVE PHONE EXTENSION	131
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	132
CLAIMANT AUXILIARY RECORD *This record is being created by ISO for additional TPOC information and for additional claimants.*			
	Will be pre-populated by ISO to default value "NGCE"	RECORD IDENTIFIER	1
	Will be pre-populated by ISO with a unique identifier for each record sent.	DCN	2
INJURED PARTY HICN UEX1 76-87 ClaimInvestigationAddRq/com.iso_SIUParty/com.iso_HICN		INJURED PARTY HICN	3
SSN UO01 93-101 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		INJURED PARTY SSN	4
LAST NAME UO01 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		INJURED PARTY LAST NAME	5
FIRST NAME UO01 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		INJURED PARTY FIRST NAME	6

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
	CLAIMANT 2 INFORMATION		
ROLE IN THE CLAIM UACL 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	ES – Estate, FA – Family Member, OC – Other Claimant. If the Individual fields are used, ISO will map to E (Estate, Individual), F (Family, Individual) or O (Other, Individual) when sending to CMS. If the Business field is used, ISO will map to X (Estate, Entity Name), Y (Family, Entity Name) or Z (Other, Entity Name) when sending to CMS. If an invalid role is reported, ISO will default the role to OC.	CLAIMANT 2 RELATIONSHIP	7
UACL 223-231 for SSN, 232-240 for TIN ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxID	If the Individual fields are used, ISO will send the SSN. If the business field is used, ISO will send the TIN.	CLAIMANT 2 TIN	8
UACL 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		CLAIMANT 2 LAST NAME	9
UACL 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		CLAIMANT 2 FIRST NAME	10
UACL 64-83 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/OtherGivenName		CLAIMANT 2 MIDDLE INITIAL	11
UACL 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		CLAIMANT 2 ENTITY/ORGANIZATION NAME	12
UACL 84-133 ClaimsParty/GeneralPartyInfo/Addr/Addr1		CLAIMANT 2 MAILING ADDRESS LINE 1	13
UACL 134-183 ClaimsParty/GeneralPartyInfo/Addr/Addr2		CLAIMANT 2 MAILING ADDRESS LINE 2	14
UACL184-208 ClaimsParty/GeneralPartyInfo/Addr/City		CLAIMANT 2 CITY	15
UACL 209-210 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		CLAIMANT 2 STATE	16
UACL 211-215 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 2 ZIP	17
UACL 216-219 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 2 ZIP + 4	18

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
UACL 241-250 ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		CLAIMANT 2 PHONE	19
	This field is Optional and will not be sent to CMS	CLAIMANT 2 PHONE EXTENSION	20
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	21
CLAIMANT 2 ATTORNEY/OTHER REPRESENTATIVE INFORMATION			
USP1 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	All lawyer roles (Claimant Lawyer -LC, Insured Lawyer- LI, Law Office Manager-LM, Law Office-LO, Paralegal- LR, Lawyer-Other- LW, Lawyer for CMS Claimant - LS) will be mapped to A = Attorney. Guardian-GU will be mapped to G = Guardian/Conservator Power of Attorney-PW will be mapped to P = Power of Attorney. Other-OR will be mapped to O = Other Since CMS will only accept one representative, if more than one representative is reported, ISO will use the following hierarchy: Attorney, Guardian, Power of Attorney, Other. ISO will only send representatives that have all required fields reported.	CLAIMANT 2 (C2) REPRESENTATIVE INDICATOR	22
USP1 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		C2 REPRESENTATIVE LAST NAME	23
USP1 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		C2 REPRESENTATIVE FIRST NAME	24
USP1 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		C2 REPRESENTATIVE FIRM NAME	25
USP1 93-101 for SSN, 102-110 for TIN. ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxId		C2 REPRESENTATIVE TIN	26
USP1 148-197 ClaimsParty/GeneralPartyInfo/Addr/Addr1		C2 REPRESENTATIVE MAILING ADDRESS LINE 1	27

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
USP1 198-247 ClaimsParty/GeneralPartyInfo/Addr/Addr2		C2 REPRESENTATIVE MAILING ADDRESS LINE 2	28
USP1 248-272 ClaimsParty/GeneralPartyInfo/Addr/City		C2 REPRESENTATIVE CITY	29
USP1 273-274 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		C2 REPRESENTATIVE STATE	30
USP1 275-279 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C2 REPRESENTATIVE ZIP	31
USP1 280-283 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C2 REPRESENTATIVE ZIP + 4	32
USP1 287-296 if Individual, 297-306 if Business ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		C2 REPRESENTATIVE PHONE	33
	This field is Optional and will not be sent to CMS	C2 REPRESENTATIVE PHONE EXTENSION	34
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	35
CLAIMANT 3 INFORMATION			
ROLE IN THE CLAIM UACL 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	ES – Estate, FA – Family Member, OC – Other Claimant. If the Individual fields are used, ISO will map to E (Estate, Individual), F (Family, Individual) or O (Other, Individual) when sending to CMS. If the Business field is used, ISO will map to X (Estate, Entity Name), Y (Family, Entity Name) or Z (Other, Entity Name) when sending to CMS. If an invalid role is reported, ISO will default the role to OC.	CLAIMANT 3 (C3) RELATIONAHIP	36
UACL 223-231 for SSN, 232-240 for TIN ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxID	If the Individual fields are used, ISO will send the SSN. If the business field is used, ISO will send the TIN.	CLAIMANT 3 TIN	37
UACL 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		CLAIMANT 3 LAST NAME	38
UACL 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		CLAIMANT 3 FIRST NAME	39
UACL 64-83 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/OtherGivenName		CLAIMANT 3 MIDDLE INITIAL	40

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
UACL 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		CLAIMANT 3 ENTITY/ORGANIZATION NAME	41
UACL 84-133 ClaimsParty/GeneralPartyInfo/Addr/Addr1		CLAIMANT 3 MAILING ADDRESS LINE 1	42
UACL 134-183 ClaimsParty/GeneralPartyInfo/Addr/Addr2		CLAIMANT 3 MAILING ADDRESS LINE 2	43
UACL184-208 ClaimsParty/GeneralPartyInfo/Addr/City		CLAIMANT 3 CITY	44
UACL 209-210 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		CLAIMANT 3 STATE	45
UACL 211-215 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 3 ZIP	46
UACL 216-219 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 3 ZIP + 4	47
UACL 241-250 ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		CLAIMANT 3 PHONE	48
	This field is Optional and will not be sent to CMS	CLAIMANT 3 PHONE EXTENSION	49
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	50
CLAIMANT 3 ATTORNEYREPRESENATATIVE INFORMATION			
USP1 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	All lawyer roles (Claimant Lawyer -LC, Insured Lawyer- LI, Law Office Manager-LM, Law Office-LO, Paralegal- LR, Lawyer-Other- LW, Lawyer for CMS Claimant - LS) will be mapped to A = Attorney. Guardian-GU will be mapped to G = Guardian/Conservator Power of Attorney-PW will be mapped to P = Power of Attorney. Other-OR will be mapped to O = Other. Since CMS will only accept one representative, if more than one representative is reported, ISO will use the following hierarchy: Attorney, Guardian, Power of Attorney, Other. ISO will only send representatives that have all required fields reported.	CLAIMANT 3 (C3) REPRESENTATIVE INDICATOR	51

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
USP1 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		C3 REPRESENTATIVE LAST NAME	52
USP1 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		C3 REPRESENTATIVE FIRST NAME	53
ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	**COMMENTS**	**CMS FIELD**	**CMS FIELD #**
USP1 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		C3 REPRESENTATIVE FIRM NAME	54
USP1 93-101 for SSN, 102-110 for TIN. ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxId		C3 REPRESENTATIVE TIN	55
USP1 148-197 ClaimsParty/GeneralPartyInfo/Addr/Addr1		C3 REPRESENTATIVE MAILING ADDRESS LINE 1	56
USP1 198-247 ClaimsParty/GeneralPartyInfo/Addr/Addr2		C3 REPRESENTATIVE MAILING ADDRESS LINE 2	57
USP1 248-272 ClaimsParty/GeneralPartyInfo/Addr/City		C3 REPRESENTATIVE CITY	58
USP1 273-274 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		C3 REPRESENTATIVE STATE	59
USP1 275-279 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C3 REPRESENTATIVE ZIP	60
USP1 280-283 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C3 REPRESENTATIVE ZIP + 4	61
USP1 287-296 if Individual, 297-306 if Business ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		C3 REPRESENTATIVE PHONE	62
	This field is Optional and will not be sent to CMS	C3 REPRESENTATIVE PHONE EXTENSION	63
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	64

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
	CLAIMANT 4 INFORMATION		
ROLE IN THE CLAIM UACL 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	ES – Estate, FA – Family Member, OC – Other Claimant. If the Individual fields are used, ISO will map to E (Estate, Individual), F (Family, Individual) or O (Other, Individual) when sending to CMS. If the Business field is used, ISO will map to X (Estate, Entity Name), Y (Family, Entity Name) or Z (Other, Entity Name) when sending to CMS. If an invalid role is reported, ISO will default the role to OC.	CLAIMANT 4 (C4) RELATIONAHIP	65
UACL 223-231 for SSN, 232-240 for TIN ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxID	If the Individual fields are used, ISO will send the SSN. If the business field is used, ISO will send the TIN.	CLAIMANT 4 TIN	66
UACL 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		CLAIMANT 4 LAST NAME	67
UACL 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		CLAIMANT 4 FIRST NAME	68
UACL 64-83 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/OtherGivenName		CLAIMANT 4 MIDDLE INITIAL	69
UACL 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		CLAIMANT 4 ENTITY/ORGANIZATION NAME	70
UACL 84-133 ClaimsParty/GeneralPartyInfo/Addr/Addr1		CLAIMANT 4 MAILING ADDRESS LINE 1	71
UACL 134-183 ClaimsParty/GeneralPartyInfo/Addr/Addr2		CLAIMANT 4 MAILING ADDRESS LINE 2	72
UACL184-208 ClaimsParty/GeneralPartyInfo/Addr/City		CLAIMANT 4 CITY	73
UACL 209-210 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		CLAIMANT 4 STATE	74
UACL 211-215 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 4 ZIP	75

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
UACL 216-219 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 4 ZIP + 4	76
UACL 241-250 ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		CLAIMANT 4 PHONE	77
	This field is Optional and will not be sent to CMS	CLAIMANT 4 PHONE EXTENSION	78
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	79
CLAIMANT 4 ATTORNEY/REPRESENTATIVE INFORMATION			
USP1 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	All lawyer roles (Claimant Lawyer -LC, Insured Lawyer- LI, Law Office Manager-LM, Law Office-LO, Paralegal- LR, Lawyer-Other- LW, Lawyer for CMS Claimant - LS) will be mapped to A = Attorney. Guardian-GU will be mapped to G = Guardian/Conservator Power of Attorney-PW will be mapped to P = Power of Attorney. Other-OR will be mapped to O = Other Since CMS will only accept one representative, if more than one representative is reported, ISO will use the following hierarchy: Attorney, Guardian, Power of Attorney, Other. ISO will only send representatives that have all required fields reported.	CLAIMANT 4 (C4) REPRESENTATIVE INDICATOR	80
USP1 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		C4 REPRESENTATIVE LAST NAME	81
USP1 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		C4 REPRESENTATIVE FIRST NAME	82
USP1 14-83 with Business Indica ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName tor		C4 REPRESENTATIVE FIRM NAME	83

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
USP1 93-101 for SSN, 102-110 for TIN. ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxID		C4 REPRESENTATIVE TIN	84
USP1 148-197 ClaimsParty/GeneralPartyInfo/Addr/Addr1		C4 REPRESENTATIVE MAILING ADDRESS LINE 1	85
USP1 198-247 ClaimsParty/GeneralPartyInfo/Addr/Addr2		C4 REPRESENTATIVE MAILING ADDRESS LINE 2	86
USP1 248-272 ClaimsParty/GeneralPartyInfo/Addr/City		C4 REPRESENTATIVE CITY	87
USP1 273-274 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		C4 REPRESENTATIVE STATE	88
USP1 275-279 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C4 REPRESENTATIVE ZIP	89
USP1 280-283 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C4 REPRESENTATIVE ZIP + 4	90
USP1 287-296 if Individual, 297-306 if Business ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		C4 REPRESENTATIVE PHONE	91
	This field is Optional and will not be sent to CMS	C4 REPRESENTATIVE PHONE EXTENSION	92
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) DATE 2 UEX3 76-83 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/com.iso_TPOCDt		TPOC DATE 2	93
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) AMOUNT 2 UEX3 84-94 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/com.iso_TPOCAmt		TPOC AMOUNT 2	94

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
FUNDING DELAYED BEYOND TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) START DATE 2 UEX3 95-102 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCStartDt		FUNDING DELAYED BEYOND TPOC START DATE 2	95
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) DATE 3 UEX3 103-110 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCDt		TPOC DATE 3	96
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) AMOUNT 3 UEX3 111-121 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCAmt		TPOC AMOUNT 3	97
FUNDING DELAYED BEYOND TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) START DATE 3 UEX3 122-129 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCStartDt		FUNDING DELAYED BEYONE TPOC START DATE 3	98
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) DATE 4 UEX3 130-137 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCDt		TPOC DATE 4	99

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) AMOUNT 4 UEX3 138-148 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCAmt		TPOC AMOUNT 4	100
FUNDING DELAYED BEYOND TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) START DATE 4 UEX3 149-156 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCStartDt		FUNDING DELAYED BEYOND TPOC START DATE 4	101
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) DATE 5 UEX3 157-164 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCDt		TPOC DATE 5	102
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) AMOUNT 5 UEX3 165-175 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCAmt		TPOC AMOUNT 5	103
FUNDING DELAYED BEYOND TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) START DATE 5 UEX3 176-183 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCStartDt		FUNDING DELAYED BEYOND TPOC START DATE 5	104
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	105

APPENDIX G - PRE-QUERY EXTRACT FILE LAYOUT

Each unique claimant/coverage will be provided on a separate line.

Position	Field Name	Length	Type	Description
THE FIELDS BELOW WILL BE PROVIDED BY ISO TO THE CUSTOMER				
1-11	ClaimSearch Identifier	11	A/N	A unique identifier created by ISO for every claim on the database.
12-41	Claim Number	30	A/N	Claim Number as reported to ISO ClaimSearch
42-45	Company Code	4	A/N	The first 4 characters of the customer ID code assigned by ISO ClaimSearch
46-50	Office Code	5	A/N	The last 5 digits of the customer ID code assigned by ISO ClaimSearch
51-80	Policy Number	30	A/N	Policy Number as reported to ISO ClaimSearch
81-90	Date of Loss	10	N	YYYY-MM-DD
91-94	Policy Type	4	A/N	Found in Appendix A of the Universal Format Manual
95-103	Person Number	9	A/N	This is a unique identifier created by ISO for every involved party on the database.
104-107	Coverage Type	4	A/N	Found in Appendix A of the Universal Format Manual
108-111	Loss Type	4	A/N	Found in Appendix A of the Universal Format Manual
112-141	Last Name	30	A/N	Claimant's Last Name
142-166	First Name	25	A/N	Claimant's First Name
167-176	Date of Birth	10	N	YYYY-MM-DD
177	Gender	1	A/N	M = Male F = Female U= Unknown Blank Field = Unknown
178-186	Social Security Number	9	N	SSN as reported to ISO ClaimSearch
187-189	Claim Status	3	A/N	O = Open C = Closed CWP = Closed without Payment
190-199	Claim Closed Date	10	N	YYYY-MM-DD
200	Universal Format or Legacy Indicator	1	A/N	U = Universal Format Claim L – Legacy Claim
201	CMS-Applicable Claim Type	1	A/N	Y = the type of claim is applicable for CMS. N = the type of claim is not applicable for CMS.
202	Run Type	1	A/N	For ISO Internal Use

Position	Field Name	Length	Type	Description
THE FIELDS BELOW MAY BE RETURNED TO ISO FOR ADDITION TO ISO's QUERY TABLE				
203-211	Applied COBC Assigned Section 111 Reporter ID (RRE Code)	9	A/N	COBC Assigned Section 111 Reporter ID for this claim. If the RRE Code you are assigned is less than 9 digits, please place zeros before the ID. EX: 000012345
212-220	Applied Social Security Number	9		SSN to be used for the query
221-230	Applied Date of Birth	10		Date of birth to be used for the query
231	Applied Gender	1		Gender to be used for the query, M = Male F = Female
232	Applied Open/Closed Indicator	3		O = Open C = Closed CWP = Closed without Payment
233-242	Applied Closed Date	10		YYYY-MM-DD Date Claim Closed

APPENDIX H – ICD-9 AND CAUSE OF INJURY, INCIDENT, OR ILLNESS CODE REPORTING TIPS

On every ADD or UPDATE claim submitted to CMS after January 1, 2011, at least one ICD-9-CM and one Alleged Cause of Injury, Incident or Illness Code is required.

Below are the requirements from CMS for ICD-9 codes:

- The ICD-9 code describes the alleged injury/illness. The CMS file layout has a 5 byte Alpha Numeric field for ICD-9 codes. In the file sent to CMS, the ICD-9 must be left justified and must include any leading zeros. The ICD-9 should be submitted with numeric values only. It should not include the decimal point. It should be space filled as needed on the right. It must be on one of the three most current lists/files of valid ICD-9 diagnosis codes accepted by CMS for Section 111 reporting found at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Codes must match ***exactly*** to one of the codes considered valid for Section 111. ***Partial matches are not accepted.*** See Section 11.2.5 of the CMS User Guide for more details. No "E" codes or "V" codes are permitted. The ICD-9 must not be on the list of Excluded ICD-9 Diagnosis codes found in Appendix H of the CMS User Manual. A code submitted for Section 111 reporting is not valid just because the NGHP RRE might have accepted the code on a medical claim submitted to them.

Reporting ICD-9 codes through ISO ClaimSearch:

- The Universal Format file layout and ClaimSearch website has a 6 byte field for ICD-9 codes vs. the 5 byte field accepted by CMS. ISO will handle left justifying the ICD-9 codes sent to CMS, but ISO cannot add any leading zeros to the ICD-9. If a valid ICD-9 code has leading zeros, you must enter the zeros. In ClaimSearch, if you enter the decimal point, ISO will strip it prior to sending to CMS. If you do not enter the decimal point, it is also fine. If the valid ICD-9 code which you enter is less than 5 bytes, ISO will add the spaces to the right of the code to meet CMS' requirements.

Below are the requirements from CMS for Alleged Cause of Injury, Incident or Illness codes:

- The Alleged Cause of Injury, Incident or Illness code is the External Cause of Injury Code "E Code" describing the alleged cause of injury/illness. The CMS file layout has a 5 byte Alpha Numeric field for Cause of Injury codes. In the file sent to CMS, the Cause of Injury code must be left justified. The code must begin with the letter "E". It should not include the decimal point. It should be space filled as needed on the right. It must be on one of the three most current lists/files of valid ICD-9 diagnosis codes accepted by CMS for Section 111 reporting found at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Codes must match ***exactly*** to one of the codes considered valid for Section 111. ***Partial matches are not accepted.*** See Section 11.2.5 of the CMS User Guide for more details. The Cause of Injury code must not be on the list of Excluded ICD-9 Diagnosis codes found in Appendix H of the CMS User Manual

Reporting Alleged Cause of Injury, Incident or Illness codes through ISO ClaimSearch:

- The Universal Format file layout and ClaimSearch website has a 5 byte field for Cause of Injury codes which is the same length as the CMS requirement. ISO will handle left justifying the Cause of Injury codes sent to CMS. You must enter the E in front of the numeric code; ISO will not add this for you. In ClaimSearch, since ISO only has a 5 byte field, **do not enter the decimal point because if you do, since some Cause of Injury codes are 5 bytes long, if you enter the**

decimal, the last digit could get dropped. If you do enter the decimal point, however, ISO will strip it prior to sending the file to CMS and will send the first 5 bytes reported. If the valid Cause of Injury code which you enter is less than 5 bytes, ISO will add the spaces to the right of the code to meet CMS' requirements.

ISO Tools to assist you with finding ICD-9 or Cause of Injury Codes

ICD-9 and Alleged Cause of Injury Valid List Spreadsheet

In order to assist you with finding ICD-9 or Cause of Injury Codes on the three most recent lists, ISO has published the lists on a spreadsheet on the Manuals & Resources section of the ClaimSearch website. The spreadsheet contains separate tabs for each of the three most current lists of valid ICD-9 and Cause of Injury codes. You should enter the codes into the system exactly as they appear on that list; codes must match exactly to the list. On the spreadsheet, ISO has highlighted in red the codes which are on the Excluded ICD-9 and Cause of Injury lists. You should not use any of those excluded codes.

ICD-9 and Alleged Cause of Injury ClaimSearch Website Look-Up Feature

If your company enters claims via the ClaimSearch website, ISO has added a look-up feature for ICD-9 and Cause of Injury codes which will allow you to enter a description of an injury or a cause of injury which will bring you to possible ICD-9 or Cause of Injury codes which are found on the three accepted CMS lists.

When using this tool, here are some tips:

1. The filter for determining the code type is removed if you delete the INJ or COI from the search field. Therefore, if you enter just the word "leg" and delete "INJ" or "COI" when searching on either, you receive codes for diagnosis and cause of injury regardless of which link you selected.

2. If you enter "left" or "right" in front of a keyword such as leg" nothing comes back, but if you enter "lower left leg" results are received. Solution - The inclusion of the word "left" is causing the issue.

   Because the CMS reportable codes have no actual LEFT/RIGHT in their descriptions, when you search on "Left leg" the search can't find codes which specifically refer to the "**left** leg". There are NO codes in there that mention LEFT or RIGHT they just refer to the "leg". If you search on "leg" only you will get results. When you search on "lower left leg", the search logic still can't find anything for "left" but rationalizes its search on a "2 out of 3" basis to use the words "lower" and "leg" which also of course yields some valid results. SUGGESTION: Do not enter the words "left or right" when searching for ICD9s on this link.

Additional Information

EXAMPLES of ICD-9 Codes:

1. 959 followed by 2 spaces is not a valid ICD-9 diagnosis code. It must be submitted with the additional digits/qualifiers after the 959, but with no decimal.

Valid choices are:

95901 Head injury, unspecified

95909 Injury of face and neck

95911 Other injury of chest wall

95912 Other injury of abdomen

95913 Fracture of corpus cavernosum

95914 Other injury of external genitals

95919 Other injury of other sites of trunk

2. On the CMS file, '037' should be submitted as '037', '038.3' should be submitted as '0383', '038.42'should be submitted as '03842'.

   When reporting to ISO ClaimSearch, '037' should be submitted as '037', '038.3' may be submitted as '038.3' or '0383', and '038.42' may be submitted as '03842' or '038.42'.

EXAMPLES OF ALLEGED CAUSE OF INJURY, INCIDENT or ILLNESS Codes

1. E885 followed by a space is not a valid Cause of Injury code. It must be submitted with an additional digit, but with no decimal.

Valid choices are:

E8850 Fall from (non-motorized) scooter

E8851 Fall from roller skates

E8852 Fall from skateboard

E8853 Fall from skis

E8854 Fall from snowboard

E8859 Fall from other slipping, tripping, or stumbling

2. On the CMS file, 'E812.0' should be submitted as 'E8120', 'E919.2' should be submitted as 'E9192', 'E956'should be submitted as 'E956'.

When reporting to ISO ClaimSearch, 'E812.0' should be submitted as 'E8120', 'E919.2' should be submitted as 'E9192', and 'E956' should be submitted as 'E956'.

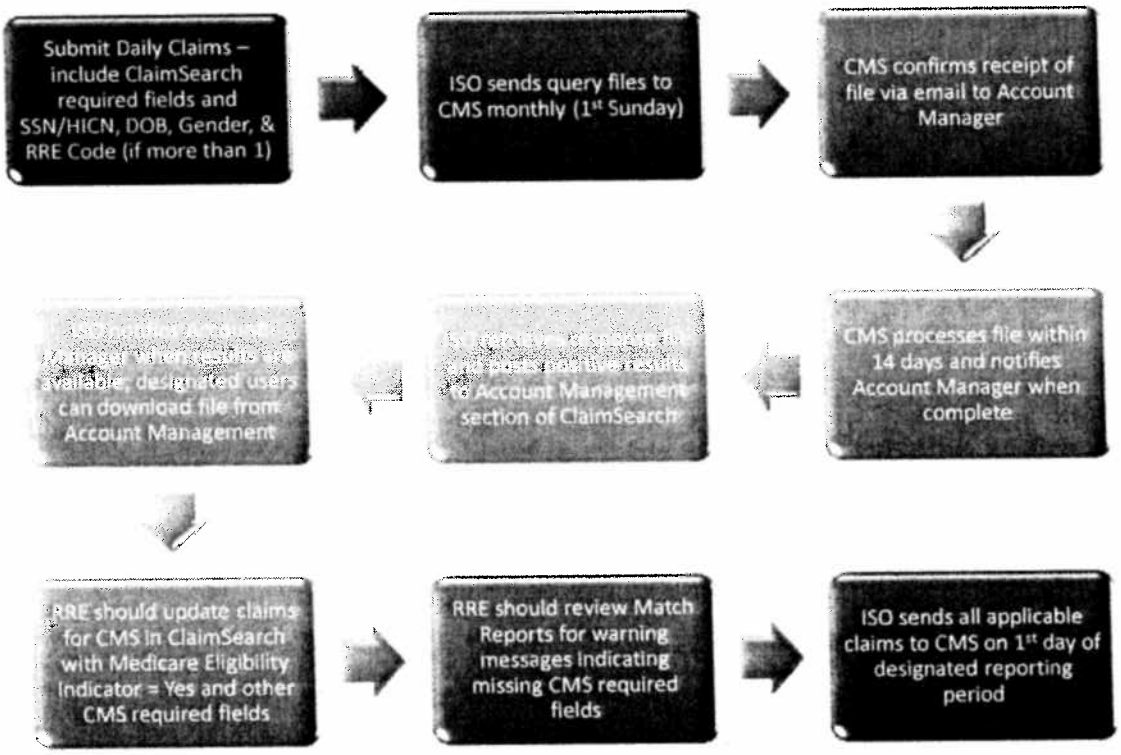
NOTE: Based on comments from a recent CMS Town Hall meeting, it is suggested not to use generic or vague diagnosis codes. If the codes used are vague, the claimant could be denied medical treatment if the recovery contractor is unable to determine the exact injury.

APPENDIX I – MEDICARE SECONDARY PAYER REPORTING SERVICE PROCESS OUTLINE

ISO ClaimSearch

Medicare Secondary Payer Reporting Service

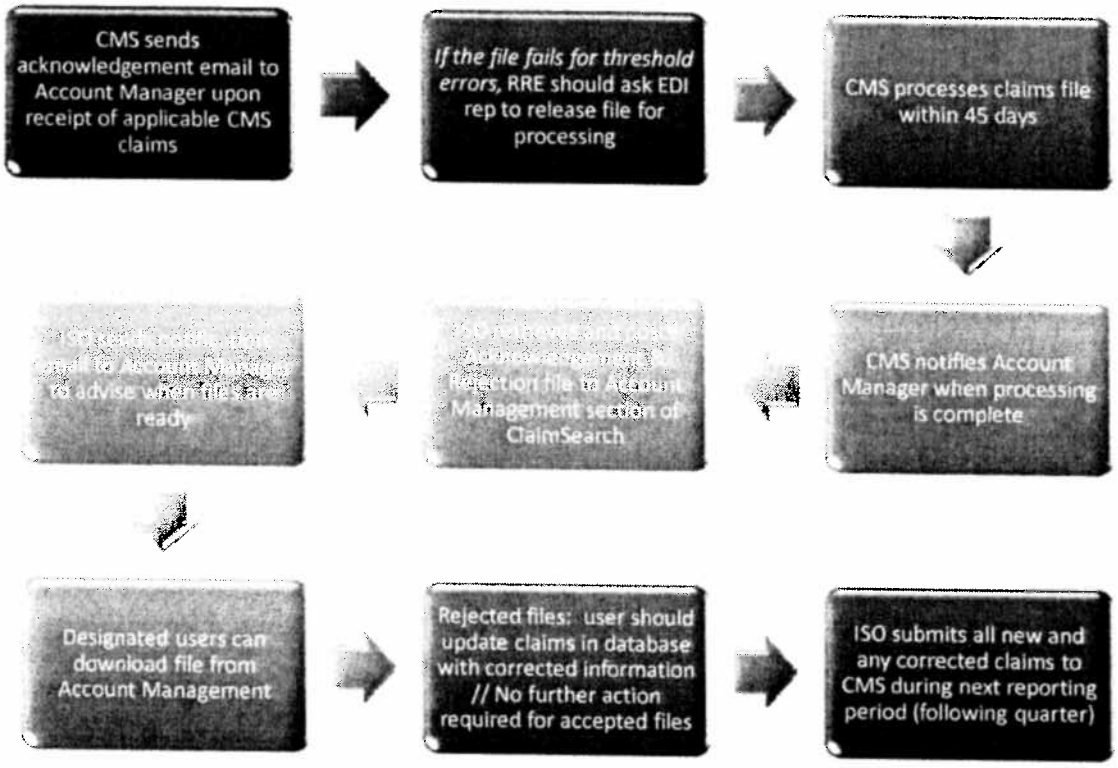
Process Outline



ISO ClaimSearch

Medicare Secondary Payer Reporting Service

Process Outline Continued



A10-0523

PRODUCT SUPPLEMENT

EXECUTED ORIGINAL

This is a Product Supplement to the ISO Master Agreement, 01/05 edition, dated September 22, 2009 by and between City of New Haven ("Licensee") and Insurance Services Office, Inc., on behalf of itself, its subsidiaries and affiliates, (all of which are collectively referred to herein as "ISO").

☒ MEDICARE SECONDARY PAYER REPORTING

This service forwards claims submitted by Licensee to the Department of Health and Human Services Center for Medicare and Medicaid Services (CMS) in compliance with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173), which imposed mandatory reporting requirements on liability, no-fault and workers compensation insurers. The legislation requires reporting of bodily injury claims filed by Medicare-eligible claimants to CMS.

The service performs reporting on behalf of the participant in compliance with the requirements and processes established by CMS. The participant may have one or more Registered Reporting Entities (RREs) as defined by CMS requirements. The participant must provide claims information meeting CMS requirements to ISO ClaimSearch.

The service also provides an error-correction process to allow the participant to correct any errors in claims they may have submitted that were rejected by CMS due to missing or inaccurate data.

ISO will also assist participants with a CMS-developed query process to help the participant determine which claimants are Medicare eligible.

Customers may also choose to participate in the separate, optional ISO ClaimSearch service, AppendDS℠ which can provide data to help the participant find information about claimants necessary to meet CMS data-reporting requirements (see AppendDS section below).

Additional Terms and Conditions Applicable to this Product:

1. Licensee hereby requests the Product(s) described herein and represents that this request is made by its authorized representative. Licensee warrants that it is in compliance with all terms of the Master Agreement between the parties. At Licensee's expense, Licensee shall provide all Licensee equipment and appropriate interfacing devices for any lines, modems and terminals compatible with the connectivity arrangement(s) selected and to pay for all costs to connect to an ISO-provided connect point or designated node, if necessary.

2. Licensee agrees that Licensee shall not reproduce, retransmit, republish, or otherwise transfer for any commercial purpose any information that Licensee receives from the Services, other than as permitted under this Product Supplement

Fee: **$4.85 per claim plus $200 Annual Participation Fee for each Required Reporting Entity (RRE):** If Licensee is an insurance company, the fee will be based on Licensee's direct written premium for the second preceding year for the Casualty line of business. If Licensee is not an insurance company, Licensee shall be invoiced monthly for each claimant submitted to CMS during the preceding month. The invoice will be based on the prices in effect at the effective date of this product supplement and the commencement date of each renewal period thereafter.

Product Supplement Term: July 1, 2010 – June 30, 2011
Term automatically renews for one-year periods unless terminated pursuant to the Master Agreement.

Except as provided herein or modified hereby, all terms, covenants and conditions of the Master Agreement remain unchanged. To the extent any provision in this Product Supplement conflicts with any similar provision in the Master Agreement, the terms set forth on this Product Supplement shall control. This Product Supplement may be executed in separate counterparts, each such counterpart being deemed to be an original instrument, and all such counterparts shall together constitute the same agreement

This Agreement is not valid against ISO unless and until executed by the appropriate ISO officer or authorized representative at the appropriate ISO home office.

☐ APPEND-DS

This service will find missing or omitted data, specifically, social security numbers and other information that the customer can append to its claim reports to complete them.

1. Licensee hereby requests the Product(s) described herein and represents that this request is made by its authorized representative. Licensee warrants that it is in compliance with all terms of the Master Agreement between the parties. At Licensee's expense, Licensee shall provide all Licensee equipment and appropriate interfacing devices; for any lines, modems and terminals compatible with the connectivity arrangement(s) selected and to pay for all costs to connect to an ISO-provided connect point or designated node, if necessary.

2. Licensee warrants that it is licensed to access an ISO ClaimSearch database. Licensee agrees that if its right to access the ISO ClaimSearch databases terminates that Licensee's right to access this Append DS Product shall also terminate.

3. Licensee accepts all information "AS IS." Licensee acknowledges and agrees that the data is obtained from third-party sources, which may or may not be completely thorough and accurate, and that Licensee shall not rely on the third-party data provider or ISO for the accuracy or completeness of information supplied.

4. Licensee warrants to the data providers and ISO that Licensee proceeds at its own risk in choosing to rely upon public records information in whole or in part. Licensee agrees that the data providers assume no responsibility for the accuracy of the information, errors that occur in the conversion of data or for Licensee's use of the information. Neither the third-party data providers, nor any third-party data provider to them (for purposes of indemnification, warranties and limitations on liability the third-party data providers and their data providers are hereby collectively referred to as third-party data providers), shall be liable to Licensee for any loss or injury arising out of or caused in whole or in part by third-party data providers' acts or omissions, whether negligent or otherwise, in procuring, compiling, collecting, interpreting, reporting, communicating, or delivering the Services. If, notwithstanding the foregoing, liability can be imposed on a provider, then Licensee agrees, that the aggregate liability for any and all losses or injuries arising out of any act or omission of a third-party data provider in connection with anything to be done or furnished under this agreement, regardless of the cause of the loss or injury shall never exceed $100.00 and Licensee agrees that it will not seek punitive damages in any suit against a third-party data provider. The third-party data providers do not make and hereby disclaim any warranty, express or implied with respect to the Services provided hereunder. The third-party data providers do not guarantee or warrant the correctness, completeness, merchantability, or fitness for a particular purpose of their Services or the components thereof or information provided hereunder. In no event shall a third-party data provider be liable for any direct, incidental or consequential damages, however arising, incurred by Licensee's receipt or use of information delivered hereunder, or the unavailability thereof.

5. Licensee agrees that Licensee shall not reproduce, retransmit, republish, or otherwise transfer for any commercial purpose any information that Licensee receives from the Services, other than as permitted under this Supplement. Licensee acknowledges that the third-party data providers shall retain all right, title, and interest in and to the data and information provided by the Services under applicable contractual, copyright, and related laws, and Licensee shall use such materials consistent with the third-party data providers' interests and notify them of any threatened or actual infringement of their rights.

6. Licensee warrants that it, its employees and authorized users of the ISO ClaimSearch Databases shall use its public records Services consistent with the privacy obligations and any other terms and provisions of the Gramm-Leach-Bliley Act (15 U.S.C. 6801 et seq.) ("GLB") or any similar state or local statute, rules and regulations, the Federal Drivers Privacy Protection Act (18 U.S.C. Section 2721 et seq.) ("DPPA") and similar state and local statutes, rules and regulations, and such legislation and rules and regulations as may be enacted or adopted after the date of this Agreement, by any federal, state or local government body. In addition, Licensee shall not use any information received from the public records Services for consumer credit purposes, consumer insurance underwriting, employment purposes, or for any other purpose covered by the federal Fair Credit Reporting Act (15 U.S.C. § 1681 et seq.) or similar state or local statute, rule, or regulation. Licensee shall abide by such legislation and rules and regulations as may be enacted or adopted after the date hereof.

7. Licensee hereby agrees that upon reasonable notice and at a mutually agreeable time, ISO may periodically audit Licensee's books and records relevant to the use of this public records Service in order to ensure compliance with the GLB and all other applicable laws. The third-party data providers shall also investigate all legitimate reports of abuse or misuse of their Services. Violations discovered in any review will be subject to immediate action including, but not limited to, termination of Licensee's right to use the public records Services, legal action, and/or referral to federal or state regulatory agencies.

Fee: $ 0.35 per Transaction (plus applicable taxes)
Licensee shall be invoiced monthly for each Append-DS transaction recorded for the applicable line of business during the preceding month. The invoice will be based on the prices in effect at the time of billing.

Product Supplement Term: July 1, 2010 – June 30, 2010
Term automatically renews for one-year periods unless terminated pursuant to the Master Agreement.

In witness whereof, the parties hereto have caused this product supplement to be executed by their duly authorized representatives.

Licensee: City of New Haven	ISO: INSURANCE SERVICES OFFICE, INC. On behalf of itself, its subsidiaries and affiliates.
Signature:	Signature: Richard Della Rocca
Print Name: John DeStefano, Jr.	Print Name: RICHARD DELLA ROCCA
Title: Mayor for City of New Haven	Title: VICE PRESIDENT ISO CLAIMS SOLUTIONS
Date:	Date: 7/12/10

☐Revised
MedicareSecondaryPayerRep.doc
April 2009 Ed.

APPROVED AS TO FORM
AND CORRECTNESS

Victor A. Bolden
Corporation Counsel

Date 6/28/10

MASTER AGREEMENT
January 2005 Edition

Agreement made this _____ day of _____, 200_9_ between Insurance Services Office, Inc., located at 545 Washington Boulevard, Jersey City, New Jersey 07310-1686, on behalf of itself, its subsidiaries and affiliates ("ISO®") and **City of New Haven** located at **165 Church Street, 4th Floor, New Haven, CT 06510** ("Licensee").

In consideration of the mutual covenants contained herein, the parties hereto agree as follows:

1. LICENSE: ISO grants to Licensee a non-exclusive, non-transferable license to use the data, products, information, services, ISO-supplied software and associated documentation ("Products") set forth in the Product Supplement(s) attached hereto and incorporated herein by reference, within the states, jurisdictions or territories of the United States of America, subject to the terms and conditions contained herein. "Agreement" shall mean this agreement, its Annexes, Exhibits and all Product Supplement(s) executed by Licensee. ISO will provide to Licensee, for sole use by Licensee, the Products described in the Product Supplement(s) provided the Licensee executes all necessary Product Supplements, and abides by the terms of this Agreement. Licensee shall use the Products solely to provide services to insurance companies that are licensed by ISO to receive and use the ISO Products for the state(s) and lines(s) of insurance or subdivision(s) thereof pertaining to the Products. Except as may be permitted under a Product Supplement(s), Licensee agrees to restrict access to all Products and the information or data therein to those employees of Licensee who have a need to use them solely in connection with the provision of the services noted above ("authorized employees"). Neither Licensee, its authorized employees, any other authorized user of the Products, nor anyone acting by or through Licensee shall sell, transfer, distribute, publish, disclose, display or otherwise make the Products available, in whole or in part, or any of the information or data therein, to any other person or entity, without the express written consent of ISO.

For the sole purpose of verifying Licensee's compliance with this Agreement, ISO may require, on at least ten (10) days prior notice, an examination and copying at ISO's expense of any and all books of account, records, documents and other materials under the control of the Licensee, and other related entities, which contain records of Licensee's use of the Products in accordance with this Agreement. All such documents shall be kept available by Licensee for at least three (3) years after the period to which they relate. ISO may exercise this right once in any twelve (12) month period. The audit will be conducted by ISO or its authorized representatives.

In the event Licensee fails to satisfy any of the conditions specified above, ISO may immediately cease providing Products to Licensee and may terminate access to the Products and thereafter notify Licensee of same.

2. TERM: This Agreement is effective on the date noted above and shall remain in force until terminated.

a. This Agreement or any Supplement may be terminated by ISO:

i. if Licensee materially violates any term or condition of this Agreement and fails to cure said violation within thirty (30) days following receipt of notice thereof from ISO. In such event, ISO may cease providing the Product(s) to Licensee. Upon Licensee curing its default hereunder to ISO's satisfaction, ISO may reinstitute the provision of and access to Products at the earliest reasonable opportunity; or

ii. if Licensee defaults in the payment of any fee(s) or charge(s) due upon ten (10) days prior notice.

iii. if ISO makes a business decision to discontinue any Product(s), and/or the maintenance and support of any Product(s) licensed hereunder, provided, however, that ISO shall provide Licensee with at least ninety (90) days notice of any such discontinuance; or

iv. immediately, if Licensee (i) terminates or suspends its business; (ii) becomes subject to any bankruptcy or insolvency proceeding under federal or state law; or (iii) becomes insolvent or becomes subject to direct control by a trustee, receiver or similar authority; or

v. for any other reason, upon one hundred eighty (180) days written notice to Licensee.

b. Licensee may terminate any Supplement, or portion thereof:

i. if ISO terminates or suspends its business; or

ii. if ISO becomes subject to any bankruptcy or insolvency proceeding under federal or state law; or

iii. if ISO becomes insolvent or becomes subject to direct control by a trustee, receiver or similar authority; or

iv. for any other reason, upon one hundred eighty (180) days written notice to ISO.

In the event of termination including expiration of this Agreement or any Supplement, ISO shall have the right to immediately cease providing Products to Licensee and immediately terminate Licensee's access to Products without notice or demand. Termination under this Section 2 shall not relieve Licensee of its obligations regarding property or copyright as specified in Sections 7. and 8. In the event of termination as a result of Licensee's failure to comply with any of its obligations under this Agreement, Licensee shall continue to be obligated for any payments due up to and including the effective date of termination. In addition, if the license to use any Product provided to Licensee electronically is terminated, Licensee will be liable and charged for payment of all termination or de-installation charges incurred by ISO related thereto, if any. Termination of this Agreement and/or any Product Supplement(s) shall be in addition to and not in lieu of any other remedies available to ISO. Upon the expiration or other termination of this Agreement, the Licensee shall immediately discontinue use of the Products, and at ISO's option, (i) return to ISO all applicable Products provided, including all manuals, associated documentation and any copies thereof; or (ii) destroy the applicable Products, including all manuals, associated documentation and any copies thereof, and certify in a writing signed by an officer of the Licensee that they have been so returned or destroyed.

3. RESTRICTION AGAINST TRANSFER OF CONFIDENTIAL INFORMATION: ISO and Licensee acknowledge that much, if not all, of the material and information which has or will come into their possession from the other party pursuant to this Agreement consists of confidential and proprietary information, nonpublic personal information or software of the disclosing party and its affiliates, agents, licensees or third parties ("Confidential Information"). The party receiving such Confidential Information agrees to hold it in strictest confidence and agrees not to release or disclose such Confidential Information to any individual or entity, whether employee, subcontractor, or subcontractor employee, except that the receiving party may disclose such information to its employees who are necessarily involved in the provision of the products and services hereunder and have agreed in writing to keep the information confidential to protect the disclosing party's interests.

a. The receiving party agrees that it shall not disclose or release any confidential, secret or proprietary information of the disclosing party or any information marked and/or designated as confidential by the disclosing party ("Confidential Information") which is disclosed to the receiving party either (i) in a writing or other tangible form or (ii) orally to any third party, except with the disclosing party's prior written consent, unless compelled to do so by legal process. In such case, the receiving party shall give the disclosing party reasonable and sufficient notice to allow the disclosing party to take action to protect its Confidential Information and trade secrets. The receiving party shall treat the disclosing party's Confidential Information in the same manner and with the same protections and safeguards as receiving party treats its own confidential information and trade secrets.

b. The party receiving Confidential Information further agrees not to (i) use the Confidential Information for its own benefit or for the benefit of any third parties, other than for the performance of its obligations under this Agreement, and (ii) release or disclose the Confidential Information to any other entity, either during the term or after the termination of this Agreement. In the event of any breach of this confidentiality obligation or of the obligations relative to the rights to products and services pursuant to this Agreement, or any product developed or delivered in providing services, the party receiving the Confidential Information acknowledges that the disclosing party would have no adequate remedy at law, since the harm caused by such a breach could not be easily measured and compensated for in the form of damages.

c. The party receiving the Confidential Information shall be solely responsible for maintaining the security of such Confidential Information and for complying with all federal, state, provincial and local laws, regulations, or other requirements including the Gramm-Leach-Bliley Act of 1999, 15 U.S.C., Section 6801, et seq. as amended from time to time governing the privacy, confidentiality and non-disclosure of such information.

d. The foregoing obligations shall not apply to any information which: a) is or becomes known publicly through no fault of the receiving party; or b) is acquired or learned by the receiving party from a third party entitled to disclose it; or c) is already known to the receiving party before receipt from the disclosing party as shown by the receiving party's written records; or d) is independently developed by the receiving party, as shown by the receiving party's written records; or e) must be disclosed by operation of law.

e. The foregoing obligations of each party shall survive the termination or expiration of this Agreement.

4. RESTRICTION AGAINST COPYING OR MODIFYING THE LICENSED PRODUCT: The Products licensed hereunder may not be copied, modified or reproduced except as provided herein unless compelled to do so by legal process. In such case, Licensee shall give ISO reasonable and sufficient notice to allow ISO to take action to protect its confidential information and trade secrets. Use of the Products does not confer the right to print, reprint, publish, copy, sell, file or use same in any manner without the written permission of the copyright owner. Licensee agrees to reproduce and incorporate ISO's copyright notice, or the third party copyright notice stated in the Products, in any copies, modifications or partial copies of the Products that Licensee makes.

5 FEES: Licensee agrees to pay all fees invoiced for Products licensed to Licensee by ISO regardless of whether Licensee actually uses any or all such Products. Licensee agrees to pay such invoices within thirty (30) days of receipt of the invoice. The fee for the initial distribution term for each Product licensed after the effective date of the Agreement is indicated on the applicable Product Supplement. ISO reserves the right to amend the fees due on prior notice to Licensee. Except for taxes based on ISO's income, Licensee shall be responsible to pay for all federal, state, and local sales, excise, use or similar taxes in connection with Licensee's license or use of the Products licensed hereunder. Interest shall be due on all charges not paid within thirty (30) days at the rate of 1% per month or the maximum interest permitted by law, whichever is less. A default in the payment of charges due for one Product may result in the termination of the license to use all Products and termination of access to Products provided to Licensee electronically. In the event Licensee desires to re-establish its license to use and/or access the Products after ISO has terminated this Agreement hereunder, and ISO agrees to provide such Products or access, Licensee shall pay all outstanding charges, as well as any administrative costs that ISO may impose, and all charges incurred by ISO in disconnecting and reconnecting Licensee access to the Products, if applicable. For any Products which will be provided to Licensee electronically, the Licensee, at its expense is required to: (a) provide all necessary Licensee equipment and appropriate interfacing devices, and (b) pay for all costs to connect to an ISO-provided connect point or designated node.

6. SECURITY REQUIREMENTS: a. Licensee agrees to comply with the following security requirements for any Products licensed hereunder. Licensee agrees that it will not attempt to circumvent any security measures contained within or associated with any Product licensed hereunder. Licensee shall not attempt to decompile, reverse engineer, or otherwise disassemble or obtain the source code of any Product provided hereunder.

b. To the extent a Product licensed hereunder is accessed electronically, the following security measures will apply. Third-party software, sometimes called "spyware", can infect a user's computer and capture data without permission. ISO is not responsible if any confidential data of Licensee or its agents is compromised in this manner. In order to protect its own data, ISO reserves the right, without prior notice, to suspend access to any ISO web application by any user or agent whose computer is infected in this manner until the infection is removed. ISO will make reasonable efforts to notify the Licensee beforehand, but circumstances may require prompt action.

c. Passwords. For those Products designated on the Product Supplement(s) as requiring a password, ISO will assign unique sign-on IDs and passwords, and Licensee and its authorized employees shall only access the Product(s) through use of the assigned sign-on IDs and passwords, which must be kept confidential. Licensee shall not distribute or divulge a valid sign-on ID and/or password to anyone except to its authorized employees, unless otherwise permitted in the Product Supplement(s) or in a separate writing by ISO. Licensee is responsible for all charges as described in the Product Supplement(s) as they relate to the use and activity charged to Licensee's sign-on IDs. ISO retains the right to change any sign-on ID and/or password at its discretion and notify Licensee sufficiently in advance so as not to interfere with Licensee's authorized continuous use of the Product(s). ISO also agrees to promptly change the password upon Licensee's request. Access to products which require a password must be discontinued simultaneously: (i) for any employee, with the end of that employee's employment with Licensee; and (ii) for any other user authorized by the Product Supplement(s), or otherwise authorized by ISO in writing, with the end of that user's relationship with Licensee. Licensee shall be liable, and indemnify ISO, for all fees and all loss or damage caused by or resulting from the continued use of Licensee sign-on ID(s) and password(s) by terminated employees or unauthorized users.

7. ACKNOWLEDGEMENT OF ISO INTELLECTUAL PROPERTY: Licensee acknowledges that ISO claims ownership of and a copyright in the Products. ISO is the owner or authorized licensee of all proprietary information contained in the Products and has the right to grant Licensee the license to use the Products in accordance with this Agreement without violating any law, rule or regulation. Licensee shall not contest or dispute, and waives any defense concerning, any valid ownership or copyright claim made by ISO in the Products. Licensee agrees not to take any action that would in any way impair, jeopardize, be inconsistent with, or violate ISO's ownership of the Product(s) or any valid ISO copyright. ISO's claims of copyright relate to all Products provided to Licensee pursuant to this Agreement, unless it is stated in the Product Supplement(s), or on the Product itself, that a Product is copyrighted by or proprietary to a third party. All applicable rights to patents, copyrights, trademarks and trade secrets in the Products, and any modifications made to the Products, and in the information or data therein, shall remain in ISO or the applicable third party. Licensee agrees that such third parties are third-party beneficiaries of this Agreement and are entitled to enforce their rights hereunder against Licensee. Nothing in this Agreement shall be construed as granting to Licensee any right, title or interest in or to any patent, trademark, copyright or other right of ISO or any applicable third party. Licensee warrants and represents that it will take all reasonable steps necessary to protect and preserve the Product(s) and the interests and rights of ISO and any applicable third parties therein, including appropriate action by instruction or agreement with its employees permitted access to the Products.

8. REQUIRED COPYRIGHT NOTICE:

a. If Product(s) are reprinted, copied or otherwise used in full, copies must reflect the copyright notice actually shown on the Product(s).

b. If Product(s) are reprinted, copied or otherwise used in part, the following legend must appear at the bottom of each page so used:

"Includes copyrighted material of Insurance Services Office, Inc. with its permission." If the material to be reprinted, copied or otherwise used is copyrighted by a third party, Licensee must obtain permission of the copyright owner to so use the material, and abide by any requirements set forth by the third party.

9. LIMITATION ON WARRANTIES; NO LIABILITIES: **OTHER THAN THOSE REPRESENTATIONS OR WARRANTIES SPECIFICALLY SET FORTH HEREIN, ISO MAKES NO REPRESENTATIONS, COVENANTS OR WARRANTIES OF ANY KIND, EITHER EXPRESS OR IMPLIED, WITH RESPECT TO THE PRODUCTS, INCLUDING BUT NOT LIMITED TO WARRANTIES OF CONDITION, QUALITY, DURABILITY, SUITABILITY, MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, OR IN RESPECT OF ANY WARRANTY ARISING BY STATUTE OR OTHERWISE IN LAW OR FROM A COURSE OF DEALING OR USAGE OF TRADE. IF THE FOREGOING LIMITATION IS HELD TO BE UNENFORCEABLE, ISO'S LIABILITY SHALL NOT EXCEED THE AMOUNT PAID TO ISO FOR THE LICENSE TO USE THE PRODUCT DURING THE TWELVE MONTH PERIOD PRECEDING THE RESPECTIVE EVENT(S) GIVING RISE TO SUCH LIABILITY OR OBLIGATION. FOR ALL PRODUCTS WHERE LICENSEE PAYS FOR THE PRODUCT ON A TRANSACTION BASIS, ISO'S LIABILITY SHALL BE LIMITED TO THE AMOUNT PAID FOR THE SPECIFIC TRANSACTION GIVING RISE TO SUCH LIABILITY OR OBLIGATION. THE INFORMATION INCLUDED IN THE PRODUCT(S) MAY BE STATISTICAL SAMPLES AND/OR ACTUARIAL CALCULATIONS, AND ISO MAKES NO WARRANTIES OR REPRESENTATIONS, EITHER EXPRESS OR IMPLIED, THAT THE PRODUCTS WILL ACCURATELY REFLECT, PREDICT OR RESEMBLE EXPERIENCE FOR THE ENTIRE INSURANCE INDUSTRY OR ANY INSURER(S). ISO SHALL HAVE NO LIABILITY FOR CONCLUSIONS THAT MAY BE REACHED BY THE LICENSEE. ALL ISO SERVICES AND PRODUCTS ARE ADVISORY AND ARE PROVIDED AS IS. ISO DOES NOT WARRANT THE COMPLETENESS, ACCURACY OR CURRENCY OF THE PRODUCT OR THE INFORMATION CONTAINED THEREIN. ISO SHALL HAVE NO LIABILITY FOR CONCLUSIONS THAT MAY BE REACHED BY THE LICENSEE**

Except as provided herein, neither ISO, its directors, officers, employees, agents, or participants shall be liable to Licensee, nor to anyone else, for any loss or damage of any kind and however caused, including without limitation, any special, incidental, indirect, consequential or exemplary damages, losses or expenses, lost profits, failure to realize expected savings or any other commercial or economic loss of any kind resulting from Licensee's improper use of the Product(s). Licensee agrees to indemnify and hold ISO harmless from and against any loss, damage, claim, suit or expense, including reasonable attorney's fees, arising out of or relating to the improper use of the Product(s) by Licensee. With respect to Product(s) provided to Licensee electronically, ISO does not warrant that access will be available during all scheduled hours of operation. ISO represents it will use best efforts to correct any ISO system malfunction causing any unavailability in a timely manner. Oral statements do not constitute warranties, shall not be relied upon by Licensee, and are not part of this Agreement.

10. INDEMNIFICATION BY ISO: Licensee shall notify ISO promptly of any claim that any Product, or Licensee's use of any Product, is improper or illegal or violates the rights of any third party. ISO agrees to defend, indemnify and hold Licensee harmless from and against any loss, cost, expense, damage or liability resulting from any claim or suit brought against Licensee based on an allegation that a Product, when properly used as permitted herein, infringes any United States copyright, trademark, patent or other intellectual property right, provided that Licensee, within fifteen (15) days of receipt of notice of any such alleged infringement, notifies ISO of such allegation in writing. ISO shall have the sole right to conduct the defense of any such claim or suit and all negotiations for its settlement or compromise, unless otherwise mutually agreed to in writing by the parties hereto. In the event that Licensee's use of any Product is held to constitute an infringement and use of that Product is permanently enjoined, ISO shall, at its option and expense, either: (i) procure for Licensee the right to continue using such Product; or (ii) modify such Product to become non-infringing; or (iii) replace such Product with an equally suitable, compatible and functionally equivalent non-infringing product; or (iv) grant Licensee a pro-rata refund of the charges paid for such Product provided that prior to paying such refund Licensee returns such Product and all copies and partial copies thereof to ISO.

Should Licensee learn of the infringement of any Product(s) licensed under this Agreement, Licensee shall promptly advise ISO in writing, and provide ISO with any available evidence of such infringement. In any such infringement suit as ISO may determine to institute to enforce its intellectual property rights, Licensee shall, at the request and expense of ISO, cooperate with ISO in all reasonable respects, including having its employees with relevant information provide such information to ISO and testify when requested by ISO, and make available to ISO any relevant records, papers, information and the like.

11. NOTICE: Unless otherwise provided in this Agreement, all notices, directions, instructions, orders, requests, demands, acknowledgments and other communications required or permitted to be given hereunder shall be in writing, addressed to the parties at their respective addresses set forth at the beginning of this Agreement or to such other addresses as one party may furnish in writing to the other, and shall be deemed properly given or made when: (i) delivered personally; (ii) made or given by prepaid telex, telegraph, facsimile or telecopier; or (iii) received by first class mail, postage prepaid, or upon the expiration of three (3) days after any such notice, direction, instruction, order, request, demand, acknowledgment or other communication is deposited in the United States mail for transmission by first class mail, postage prepaid, whichever shall occur first.

12. SURVIVAL OF TERMS: The terms and conditions set forth in Sections 2 through 4, and 6 through 14 shall survive the termination of this Agreement, except as may be provided in the provisions themselves.

13. CHOICE OF LAW AND EXCLUSIVE JURISDICTION AND VENUE FOR ADJUDICATING ANY DISPUTE: This Agreement shall be governed by and construed in accordance with the laws of the State of New York as an agreement made and wholly performed therein. Any litigation, action, or proceeding arising out of any dispute concerning or otherwise attempting to enforce, interpret, or remedy any breach of this Agreement shall be brought only in a court of competent jurisdiction (whether federal or state) sitting within the State and County of New York. The parties irrevocably and unconditionally (a) submit to personal jurisdiction in the State of New York and consent to venue in the County of New York with respect to any such action, (b) waive any objection to the jurisdiction and venue in the State and County of New York, and (c) agree not to plead or claim in any such court that any such suit, action or proceeding has been brought in an inconvenient forum.

14. COUNTERPARTS. This Agreement may be executed in separate counterparts, each such counterpart being deemed to be an original instrument, and all such counterparts shall together constitute the same agreement

15. GENERAL: This Agreement, its Annexes, Exhibits and Product Supplement(s), constitutes a fully integrated contract and states the entire Agreement between the parties. It supersedes and merges any and all prior discussions, representations, demonstrations, negotiations, correspondence, writings and other agreements and together states the entire understanding and agreement upon which ISO and Licensee rely respecting the subject matter of this Agreement. The captions or headings used in this Agreement are for convenience and in no way define, limit or enlarge the scope of this Agreement or any of its Sections. This Agreement, and the Annexes and Product Supplements, may be changed or modified only in writing signed by authorized representatives of both parties. If any provision of this Agreement is determined to be invalid under any applicable statute or rule of law, it is, to the extent invalid, deemed to be omitted and the remaining provisions of the Agreement shall continue in full force and effect. The failure or delay of either party to insist upon the performance of any of the terms of this Agreement in any one or more instances will not be construed as a waiver or relinquishment of the future performance of any such term, and the obligation of the parties with respect to any such future performance will continue in full force and effect. No action, regardless of form, arising out of this Agreement may be brought by Licensee more than one year after the cause of action has arisen. This Agreement inures to the benefit of and is binding upon the successors and assigns of ISO and may be assigned by ISO to any of its subsidiaries, affiliates, or related companies. It likewise inures to the benefit of Licensee, but no interest herein shall be transferred or assigned in any manner by Licensee.

This contract is not valid against ISO unless and until executed by the appropriate ISO officer or authorized representative at the appropriate ISO home office.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement by their authorized representatives as of the day and year first above written.

CITY OF NEW HAVE LICENSEE	INSURANCE SERVICES OFFICE, INC. on behalf of itself, its subsidiaries and affiliates(ISO)
Signed: _____	Signed: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

January 2005 Edition Master Agreement .doc

From: "ISO ClaimSearch MSP" <claimsearchmsp@iso.com>
To: <ppernal@newhavenct.net>
Date: 9/19/2013 9:02 AM
Subject: MMSEA Section 111 Bulletin: Summary of CMS Changes

If you are having trouble reading this e-mail, read the online version <http://s891.t.en25.com/e/es?s=891&e=79920&elq=94a35c1becf446bca9260682d4fd1141>.

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MMSEA Section 111 Bulletin:
Summary of CMS Changes

To help with your claims reporting for the ISO ClaimSearch® Medicare Secondary Payer Reporting Service, here's a summary of changes affecting CMS reporting.

TPOC THRESHOLD REDUCED

For TPOCs dated on or after October 1, 2013, the reporting threshold for Liability and Workers' Compensation will be reduced to $2,000 (from the current $5,000). The primary effect of this change is that you will likely see more reportable claims. Please modify your processes to begin sending all TPOCs above $2000 as of 10/1/13. The minimum threshold remains at $300; TPOCs below $300 will be rejected by CMS.

CAUSE OF INJURY and NON-MEDICARE BENEFICIARY RECOMMENDATIONS

With the recent change from CMS to make the Cause of Injury code ("E-Code") and identification of the payee in the event of death of the claimant (Non-Medicare Beneficiary) optional, ISO ClaimSearch will continue to allow you to report this optional information to CMS. However, to prevent unnecessary CMS rejections for optional fields, this information will be validated by ISO ClaimSearch and will only be reported to CMS if the information reported in these fields is valid.

ICD-10 PREPARATION

Effective with dates of injury beginning October 1, 2014, CMS will require ICD-10 diagnosis codes, replacing the current ICD-9 codes used for Section 111 reporting. Because these codes are supplied by the provider community, if you enter claims via the ISO ClaimSearch website, your changes should be minimal. For example, you'll be able the enter ICD-10 codes received or looked up through the ISO ClaimSearch look-up tool or spreadsheets of valid codes. If you enter claims through system-to-system reporting, your claims systems must be capable of recording and forwarding ICD-10 codes. ISO ClaimSearch will be fully prepared for this change in the test environment early in the 4th quarter of 2013. Changes will include the addition of the new ICD-10 diagnosis and Cause of Injury codes on the ISO ClaimSearch website and in the record layouts for system-to-system companies, an updated lookup table and spreadsheet to include ICD-10 codes in addition to the current ICD-9 capability, and new warning messages to alert you when you have entered an invalid code. (Diagnosis coding for pre-10/1/2014 injuries can continue to utilize ICD-9 codes indefinitely.) CMS has announced a 6-month grace period before the ICD-10 requirement will be enforced and ISO ClaimSearch will incorporate this rule as well. Additional detailed information will be provided later this year with updates as the 2014 implementation date approaches.

We will continue to monitor these changes and provide updates as needed. For more information, please contact the ISO Customer Support Center at 1-800-888-4476 or at ClaimSearchMSP@iso.com.

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This e-mail message is from:
ISO • 545 Washington Boulevard • Jersey City, NJ 07310 • 800.888.4476
This message is intended for: ppernal@newhavenct.net
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From: "ISO ClaimSearch MSP" <ClaimSearchMSP@iso.com>
To: <ppernal@newhavenct.net>
Date: 6/26/2013 2:59 PM
Subject: MMSEA Section 111 Bulletin: June 11th ICD-10 Alert

If you are having trouble reading this e-mail, read the online version <http://s891.t.en25.com/e/es?s=891&e=74738&elq=ea42771418fd4a918ae9401b2763f92b>.

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MMSEA Section 111 Bulletin:
June 11th ICD-10 Alert

On June 11, 2013 the Centers for Medicare & Medicaid Services (CMS) released an Alert regarding the plan to integrate ICD-10 codes into Section 111 reporting, while phasing out the use of ICD-9 codes. The following items contained in the Alert merit notice by ISO ClaimSearch and ISO Crowe Paradis customers:

• ICD-10 data will be required in phases – CMS announced that ICD-10 codes will only be required for injuries occurring on or after April 1, 2015. ICD-10 codes will be required for medical providers as of October 1, 2014. It is important to emphasize that ICD-10 codes will only be required for injuries occurring on or after April 1, 2015. This means that ICD-10 data will not be required for claims that are reported for nearly two years.

• ICD-9 codes will be accepted indefinitely – For injuries occurring prior to April 1, 2015, CMS will continue to accept ICD-9 codes. The Section 111 reporting record layout will be modified to create an indicator allowing a reporting agent or RRE to note whether reported codes are either ICD-9 or ICD-10.

• No simultaneous reporting – CMS' record layout will not support simultaneous reporting of ICD-9 and ICD-10 codes on the same reported claim. For claims with dates of injury occurring prior to April 1, 2015, RREs will need to report with either ICD-9 or ICD-10 codes but not both.

• CMS will not accept ICD-10 codes until October 1, 2014 – Providers will be required to use ICD-10 codes as of October 1, 2014. CMS will not accept ICD-10 on production claim input files until that same date – October 1, 2014. Until that date, RREs should only utilize ICD-9 codes.

We will continue to monitor these changes and provide updates, including updates specific to your program, if and as required. For more information, please contact the ISO Customer Support Center at 1-800-888-4476 or at ClaimSearchMSP@iso.com <mailto:ClaimSearchMSP@iso.com>, or contact your ISO Crowe Paradis representative or email mspnavigator@cpscmsa.com <mailto:mspnavigator@cpscmsa.com>.

ISO and ISO Crowe Paradis are members of the Verisk Insurance Solutions group at Verisk Analytics. For more information, visit www.iso.com <http://www.iso.com?elq=ea42771418fd4a918ae9401b2763f92b&elqCampaignId=678> and www.cpscmsa.com <http://www.cpscmsa.com?elq=ea42771418fd4a918ae9401b2763f92b&elqCampaignId=678>.

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From: "Centers for Medicare & Medicaid Services" <cmslists@subscriptions.cms.hhs.gov>
To: <ppernal@newhavenct.net>
Date: 6/27/2013 10:24 AM
Subject: The ICD-10 Deadline is October 1, 2014

News Updates | June 27, 2013

The ICD-10 Deadline is October 1, 2014

The compliance deadline for ICD-10 is *October 1, 2014*. CMS Administrator Marilyn Tavenner has affirmed the ICD-10 deadline* *and encourages providers, payers, and vendors across the health care industry to prepare to use the new codes for services provided on or after October 1, 2014.

The CMS website [http://www.cms.gov/ICD10] offers a variety of resources targeted to payers [http://cms.gov/Medicare/Coding/ICD10/Payer_Resources.html], providers [http://cms.gov/Medicare/Coding/ICD10/ProviderResources.html], vendors [http://cms.gov/Medicare/Coding/ICD10/Vendor_Resources.html], and others to help you with your transition to ICD-10. Timelines, checklists, fact sheets, and in-depth guides are all available to help you and your organization plan for a smooth transition.

Keep Up to Date on ICD-10
Visit the CMS ICD-10 website [http://www.cms.gov/ICD10] for the latest news and resources to help you prepare for the *October 1, 2014*, deadline.

Department of Health and Human Services [http://hhs.gov] Centers for Medicare & Medicaid Services [http://www.cms.gov]

Questions? Contact Us [http://www.cms.gov/ContactCMS/]

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This service is provided to you by the Office of E-Health Standards & Services, ICD-10. [http://www.cms.gov/ICD10]

This e-mail was sent to ppernal@newhavenct.net using GovDelivery, on behalf of the Centers for Medicare & Medicaid Services (410-786-5473) · 7500 Security Boulevard · Baltimore MD 21244

ISO ClaimSearch® Medicare Secondary Payer Section 111 update

The Centers for Medicare and Medicaid Services (CMS) has released service enhancements and new training materials. As a result, ISO has made some modifications to the ISO ClaimSearch® Medicare Secondary Payer Reporting Service.

Training materials

To assist responsible reporting entities (RRE) in registering and reporting, CMS recently released its latest user guide, version 3.3, for reporting claims on Medicare-eligible claimants in compliance with the MMSEA Section 111 requirements and the *CMS Quick Reference Guide.*

Extension of reporting limit

CMS is now providing a voluntary extension of the reporting limit for liability TPOCs (total payment obligation to the claimant). The amounts of the extensions decrease over time, as reflected below:

TPOC reporting extension amount	TPOC dates	Minimum liability TPOC amount (threshold)	Begin reporting
$100,000 and above	10/1/11 – 3/31/12	$5,000	1st quarter 2012
$50,000 – 99,999	4/1/12 – 6/30/12	$5,000	3rd quarter 2012
$25,000 – 49,999	7/1/12 – 9/30/12	$5,000	4th quarter 2012
$5,000 – 24,999	10/1/12 – 12/31/12	$5,000	1st quarter 2013
$2,000 – 4,999	1/1/13 – 12/31/13	$2,000	2nd quarter 2013
$600 – 1,999	1/1/14 – 12/31/14	$600	2nd quarter 2014
$0 – 599	1/1/15 – indefinite	$0	2nd quarter 2015

ISO ClaimSearch Medicare Secondary Payer Reporting Service participants have the option of reporting only claims above the voluntary extension or reporting without the extension, in which case, the minimum threshold (currently $5,000) would apply.

Profile report verification process

Effective January 1, 2012, CMS initiated a profile report verification process requiring all RREs to verify the information in their profile reports and advise CMS of any changes within ten days. Failure to respond could result in deactivation from CMS reporting. In addition, ISO ClaimSearch Medicare Secondary Payer Reporting Service participants should notify ISO of any changes to their profiles so that we can keep our records current.

We recently released *ISO ClaimSearch Medicare Secondary Payer Reporting Service User Guide* version 3.6. Updates include recent CMS reporting service enhancements and other important ISO ClaimSearch Medicare Secondary Payer Reporting Service improvements outlined in the Summary of Changes section of the manual.

Please contact the ISO Customer Support Center at 1-800-888-4476 or send e-mail to claimsearchmsp@iso.com for more information. ✦

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Office of Financial Management/Financial Services Group

September 30, 2011

Medicare Secondary Payer Mandatory Reporting Provisions in
Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)
(See 42 U.S.C. 1395y(b)(7)&(b)(8))

ALERT

Revised Implementation Timeline for Certain Liability Insurance (Including Self-Insurance) Total Payment Obligation to the Claimant (TPOC) Settlements, Judgments, Awards or Other Payments

The Centers for Medicare & Medicaid Services (CMS) has delayed Section 111 reporting for certain liability insurance (including self-insurance) TPOC settlements, judgments, awards, or other payments. The implementation date for reporting will be based on the TPOC amount. Below is a schedule of the new dates.

TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over $100,000	October 1, 2011	January 1, 2012
TPOCs over $50,000	April 1, 2012	July 1, 2012
TPOCs over $25,000	July 1, 2012	October 1, 2012
All TPOCs over min. threshold	October 1, 2012	January 1, 2013

The CMS has not changed any other MMSEA Section 111 implementation dates. See the applicable MMSEA Section 111 User Guide. In addition, other relevant information, including explanations of TPOC, ORM, and a Responsible Reporting Entity, can be found in the User Guide. (Note: This delay is optional).

The content of this ALERT supersedes the content of the existing User Guide (Version 3.2) and will be incorporated into the next version of the User Guide. After full implementation of the Section 111 reporting requirements, CMS will use the normal notice of proposed rulemaking process for establishing any penalties.

(4/10/2012) Paula Pernal - MMSEA Section 111 Bulletin

From: "ClaimSearchMSP" <claimsearchmsp@iso.com>
To:
Date: 4/9/2012 11:00 AM
Subject: MMSEA Section 111 Bulletin

<http://blog.cpscmsa.com/>

MMSEA Section 111 Bulletin:

Liability TPOC Reporting Extension

Amount Resets as of April 1, 2012

The current phase of CMS' MMSEA Section 111 reporting for liability TPOCs (settlements, judgments, awards, or other payments) commenced on April 1, 2012.

Previously, liability TPOCs greater than $100,000 for TPOC dates from October 1, 2011 through March 31, 2012 were reportable under CMS' Section111 reporting directives.

Starting April 1, 2012, the liability TPOC reporting extension was reduced from $100,000 to $50,000. Thus, all liability TPOCs greater than $50,000 for TPOCs on or after April 1, 2012 through June 30, 2012 are now reportable.

Looking ahead, the liability TPOC reporting extension amounts are then scheduled to reset again on July 1, 2012 and October 1, 2012. Thereafter, the threshold amounts will change in 2013 and 2014.

The following provides an outline of CMS' current liability TPOC reporting dates and mandatory or optional thresholds:

Dates

Mandatory Threshold

Optional Threshold

10/1/11 -- 3/31/12

Claims > $100,000

Claims > $5,000

4/1/[illegible] 6/30/12

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicare & Medicaid Services (CMS)

MMSEA Section 111 Mandatory Insurer Reporting

Quick Reference Guide

Version 1
January 19, 2012

For

Non-Group Health Plan (NGHP) Insurers

The What, Why and How of MMSEA Section 111 Reporting

The Centers for Medicare & Medicaid Services (CMS) refers to liability insurance (including self-insurance), no-fault insurance and workers' compensation as "Non-Group Health Plan" (NGHP) insurance. This MMSEA Section 111 Quick Reference Guide has been developed to help NGHP insurers understand the MMSEA Section 111 reporting requirements.

Specifically this guide will:

- Explain MMSEA Section 111 reporting, and how it may affect you
- Help you determine if you are an MMSEA Section 111 "Responsible Reporting Entity" (RRE)
- Provide an overview on how to set up and begin reporting
- Describe the various options you have for reporting
- Outline the data "input and response" process
- Identify resources for additional instruction and information on how to access free computer based training and other resources

Note: This document was prepared by the CMS for informational purposes only. All affected entities are responsible for following the instructions found in the MMSEA Section 111 NGHP User Guide which is available for download at the following link: http://www.cms.gov/MandatoryInsRep/Downloads/NGHPGuideV3.3.pdf.

What is MMSEA Section 111 Reporting?

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 is usually referred to as MMSEA Section 111 reporting (or simply Section 111). This law added *mandatory* reporting requirements for liability insurers (including self-insurers), no-fault insurers, and workers' compensation insurers providing coverage to Medicare beneficiaries. These Non-Group Health Plan (NGHP) insurers are obligated to notify Medicare about "settlements, judgments, awards, or other payment from liability insurers (including self-insurers), no-fault insurers, and workers' compensation" received by or on behalf of Medicare beneficiaries. The reporting requirements for NGHP insurers under MMSEA Section 111 first became effective on May 1, 2009.

The MMSEA Section 111 reporting requirements is *an addition* to the already existing Medicare Secondary Payer (MSP) law and corresponding regulations.

What is Medicare Secondary Payer – MSP?

Medicare Secondary Payer (MSP) is the term used to describe situations where another insurer has primary payment responsibility for care provided to a Medicare beneficiary.

Until 1980, Medicare was a primary payer for covered beneficiaries in almost all cases, except those involving workers' compensation (and black lung disease). Starting in 1980, the addition of the MSP provisions of the Social Security Act required that when the injured party is a Medicare beneficiary, Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance and workers' compensation.

Why is there an MSP law?

The MSP provisions of the Social Security Act were enacted so that some of the costs of caring for Medicare beneficiaries could be borne by other types of insurance. Spreading payment for health care coverage costs across multiple insurers is helping to extend the life of the Medicare Trust Fund, and is helping to ensure that Medicare beneficiaries have adequate access to care.

For more information and guidance about Medicare Secondary Payer (MSP) issues, please refer to "Section 5.4 - MSP Statutes, Regulations, and Guidance" in the NGHP User Guide.

I may be an "NGHP" insurer. Do I need to report under MMSEA Section 111?

You most likely will need to report under MMSEA Section 111 if you are "an applicable plan" – meaning that you are a liability insurer (including a self-insurer), an insurer providing "no-fault" coverage, or a workers' compensation plan. These are the main general categories of NGHP insurance types. In all cases, you provide insurance coverage or payments for medical expenses for someone who is a Medicare beneficiary. Please see Appendix H in the NGHP User Guide for a comprehensive discussion of the types of insurers that must report.

If you have determined that you need to report under MMSEA Section 111, you are the entity responsible for complying and will be will be referred to as the "Responsible Reporting Entity" or the "RRE".

Who do I report to?

Insurers are to report coverage to the Centers for Medicare & Medicaid Services – CMS – the Federal agency that manages the Medicare program. Since the start of MMSEA Section 111 reporting, almost 30,000 RREs are now sending MMSEA Section 111 data to CMS.

In order to manage the huge volume of MMSEA Section 111 data and other Coordination of Benefits (COB) work that Medicare handles, CMS has engaged the Coordination of Benefits Contractor (COBC) to manage the technical aspects of the Section 111 data exchange process for all Section 111 RREs. The RREs (or their data management agents) transmit information electronically to the CMS COBC.

I have determined that I need to comply with the MMSEA Section 111 reporting requirements. How do I sign up for it?

Insurers that need to report under MMSEA Section 111 become Responsible Reporting Entities (RREs) by registering on the Section 111 COB Secure Website (COBSW), a website established by CMS and managed by the COBC. RREs are required to register on the COBSW to notify the COBC of their intent to report data in compliance with Section 111.

To begin the registration process, go to the Section 111 COBSW at the following URL: http://www.section111.cms.hhs.gov and click the [I Accept] link at the bottom of the page. When the Section 111 COBSW Login page displays, click [New Registration]. You will be required to enter specific data and submit your registration. Once you have registered and completed your account setup for MMSEA Section 111 reporting on the Section 111 COBSW, you become a registered RRE. For more information on the registration process, please see the "How to Get Started" document found at the following link: https://www.section111.cms.hhs.gov/MRA/help/how_to/GetStarted.htm.

What information do I report? What will I be sending to the COBC?

Section 111 requires RREs to report claim information for Medicare beneficiaries after the insurer has assumed ongoing responsibility for medicals (ORM) or after paying the total payment obligation to the claimant (TPOC) in the form of a settlement, judgment, award, or other payment.

RREs must report evidence of insurance coverage, or applicable settlements, judgments, awards, or other payments regardless of whether there is admission or determination of liability. Some of the required data that must be reported includes: the identity of the claimant (their Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN), the first letter of their first name, the first six letters of their last name, their date of birth, and gender); the RRE Tax-ID Number (TIN); RRE address information; and other information related to the claimant such as International Classification of Diseases 9th revision (ICD-9) Diagnosis Codes; and, TPOC Dates and Amounts.

For more information on the specific data required, please see Appendix A and Appendix B in the NGHP User Guide.

How do I know or determine if I'm insuring a Medicare beneficiary?

Most Medicare beneficiaries are at least age 65. However, an individual of almost any age may be enrolled in the Medicare program. Medicare is a health insurance program for:

- People age 65 or older
- People of any age who have certain designated disabilities
- People of any age who have End-Stage Renal Disease (ESRD - permanent kidney failure)

When an individual is eligible for coverage and enrolls in Medicare, he or she is issued a "Medicare HICN", which is better known as the Medicare ID. The Medicare HICN/ID is derived from the individual's SSN. All Medicare beneficiaries will have a Medicare HICN and an SSN.

You will know if an individual is a Medicare beneficiary if you have been given the person's Medicare HICN. The easiest way to check for eligibility is to simply ask individuals you are insuring to give you their Medicare HICN. If you are unable to readily determine Medicare beneficiary status, the CMS provides a query process (search mechanism) as part of the Section 111 reporting process to assist you. In order to use the query process, you must be a registered RRE. Once registered, RREs must implement a procedure in their claims review process to determine whether the claimant is a Medicare beneficiary or if the claimant anticipates receiving Medicare benefits in the future.

How do I send the required information to the COBC?

MMSEA Section 111 reporting information can be exchanged with the COBC using any one of four methods. The first three methods involve the submission of electronic files.

- **HTTPS** – Hypertext Transfer Protocol over Secure Socket Layer: Using HTTPS, an RRE can transmit files via the Internet directly to the Section 111 COBSW and receive response files in the same manner. This method is recommended for RREs sending less than 24,000 records on a regular basis.
- **SFTP** – Secure File Transfer Protocol: Using SFTP software, an RRE can transmit files via the Internet directly to the COBC. The RRE will have a dedicated "mailbox" on the COBC's Section 111 SFTP Server, where the RRE will send input files and retrieve response files. This method can handle large amounts of data.
- **Connect:Direct –** This system provides a direct file transmission connection to the COBC mainframe using the CMS Extranet Network and CMS's private CMSNet. This is the most costly transmission method, but it is the most efficient for RREs that will be exchanging very large amounts of MMSEA Section 111 data with CMS.
- **Direct Data Entry (DDE)** – Using DDE, an RRE will manually enter claim information using an interactive application that will be accessed directly from the Section 111 COBSW. DDE can only be used by small reporters.

For more information on any of these data submission methods, please see "Section 15 – Electronic Data Exchange" in the NGHP User Guide.

Should I use Direct Data Entry?

Direct Data Entry, or DDE, is the simplest method of reporting MMSEA Section 111 data. DDE reporting is done through the Section 111 COBSW. DDE is designed for smaller RREs that don't expect to report much claim information under Section 111 (i.e., less than 500 claim reports per year). RREs using the DDE reporting option will manually key claim information into pages (screens) on the Section 111 COBSW. Once the claim is submitted and the COBC has completed its' processing, a response will be sent to the RRE via the Section 111 COBSW. For more information on the DDE process, please see the Section 111 COBSW User Guide which is available for download from the Section 111 COBSW under the 'Reference Materials' menu option. You must be logged into the Section 111 COBSW to gain access to the Section 111 COBSW User Guide.

Here are some important facts about DDE:

- An RRE can make, correct or update an MMSEA Section 111 claim report *at any time*.
- Although a separate query function is not available to DDE submitters, the initial step in the DDE process provides the same functionality.
- RREs using DDE can submit no more than 500 records a year.
  - All new DDE submissions for any purpose (even those where the Injured Party is not identified as a Medicare beneficiary) count against this annual limit.
  - Updates or deletes to a *previously submitted and* <u>*accepted*</u> claim report <u>do</u> count toward this limit.
  - Corrections to a *previously submitted, but* <u>*not yet accepted*</u> claim report due to errors, <u>do not</u> count against this limit.

How often do I submit my claim information?

RREs submitting electronic files must submit new or changed information on a quarterly basis during the RREs assigned 7-day file submission timeframe unless the RRE has nothing to report for a particular quarter. RREs using DDE to report must submit claim information one claim report at a time as soon as the conditions related to the claim require reporting under Section 111.

How do I know if what I sent was OK?

When the COBC receives a Claim Input File (or a DDE claim report), it will edit the data and determine whether the submitted information identifies the injured party as a Medicare beneficiary. When this processing is complete or the prescribed time for response file generation has elapsed, the COBC will electronically transmit a response file (for file submitters), or a response record (for DDE submitters).

Note: Each submitted record will receive a response. The response will include a disposition code that will give the RRE the results of the processing. The response will also include any error codes or compliance flags, which will identify any problems found with the data. The RRE must take the appropriate action, if any, based on the information received. If errors were received, they must be corrected and resubmitted in the RRE's next quarterly claim submission (file submitters), or as soon as the error has been corrected (DDE submitters).

Do I have to do this reporting myself? Can I hire a commercial data management firm to do it for me?

Once an RRE has registered, the RRE can delegate reporting responsibility to another entity such as a "data reporting agent" (e.g., a third party administrator or vendor) to manage the RRE's MMSEA Section 111 data exchanges with the COBC. Many do. If an RRE uses an agent to manage its MMSEA Section 111 reporting, here are some important points to keep in mind:

- You, the RRE, not your agent, are the Responsible Reporting Entity. You cannot assign your responsibility to report to your agent. The RRE is ultimately responsible for the reporting and will be held liable for non-compliance.
- You, the RRE, not your agent, are responsible for the content of the data and its' validity.
- Your agent may not use any MMSEA Section 111 reporting data other than to report for Section 111. The data belongs to the RRE and to the CMS, not to the agent.
- Your agent may use any data exchange transmission method acceptable to CMS.
- CMS does not make any recommendations about any potential reporting agents.

What MMSEA Section 111 reporting resource materials are available?

MMSEA Section 111 Mandatory Insurer Reporting Web site: The most important online resource is the official MMSEA Section 111 Mandatory Insurer Reporting Web site located at the following URL: http://www.cms.gov/mandatoryinsrep. The updated NGHP Section 111 User Guide and Section 111 Alerts can be found on this Web site.

Free Computer Based Training (CBT) Courses: CMS has made available a curriculum of computer based training (CBT) courses to Section 111 RREs. These courses are offered free of charge and provide in-depth training on Section 111 registration, reporting requirements, using the Section 111 COBSW, data transmission, file formats, file processing, Direct Data Entry, and general MSP topics. To register for the NGHP CBT courses, send an e-mail to: Section111CBT@EHMedicare.com. Specify that you are requesting the NGHP curriculum and include your company name and the name, phone number (formatted: ###-###-####) and e-mail address for the individual(s) you would like to register. Once the COBC has processed your company's request, an e-mail notification will be sent to each individual that contains the URL for the NGHP curriculum and the URL for the MSP curriculum. If you do not receive an e-mail notification within 2 business days of your request, you may contact the COBC's Electronic Data Interchange (EDI) Department at: 646-458-6740.

Section 111 Town Hall Teleconferences: From time to time CMS holds national Section 111 Town Hall Teleconferences that you may participate in. During these calls CMS addresses many of the questions and comments it receives through the Section 111 mailbox. Information about upcoming Town Hall Teleconferences is posted on the official MMSEA Section 111 Mandatory Insurer Reporting Web site at: http://www.cms.gov/mandatoryinsrep.

EDI Representative: Once an RRE has registered they will be assigned their own EDI Representative to assist them in managing all aspects of the Section 111 reporting process, from answering the simplest questions to helping them address the most complex problems.

Can I contact CMS directly with questions or comments?

If you have questions or concerns you want to communicate to CMS directly, you can use the dedicated Section 111 Mailbox at: PL110-173SEC111-comments@cms.hhs.gov.

We hope this Section 111 Mandatory Insurer Reporting Quick Reference Guide has been useful. If you have comments, questions on subjects not covered here, or suggestions about how this Quick Reference Guide can be improved, please feel free to send them to the dedicated Section 111 Mailbox at: PL110-173SEC111-comments@cms.hhs.gov. Please put "Quick Reference Guide" in the Subject line.

From: "techsupport" <techi@nhassociates.net>
To: "techsupport" <techi@nhassociates.net>
Date: 1/29/2012 5:37 PM
Subject: MMSEA Section 111 Quick Reference Guide

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MMSEA Section 111 Quick Reference Guide

The Centers for Medicare & Medicaid Services (CMS) has developed an MMSEA Section 111 Quick Reference Guide to help Non-Group Health Plan (NGHP) insurers understand the MMSEA Section 111 reporting requirements. This guide:

- Explains MMSEA Section 111 reporting, and how it may affect you
- Helps you determine if you are an MMSEA Section 111 "Responsible Reporting Entity" (RRE)
- Provides an overview on how to set up and begin reporting
- Describes the various options you have for reporting
- Outlines the data "input and response" process
- Identifies resources for additional instruction and information on how to access free computer based training and other resources

This guide has been posted to the Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation (NGHP) section page. To access this document go to this URL:
https://www.cms.gov/MandatoryInsRep/Downloads/NGHPQuickRef.pdf

Thank you,

The Centers for Medicare & Medicaid Services
NHA Learning Management Team

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Section 111
Mandatory Reporting

User Agreement

THE FOLLOWING DESCRIBES THE TERMS AND CONDITIONS BY WHICH THE CENTERS FOR MEDICARE MEDICAID SERVICES (CMS) OFFERS YOU ACCESS TO THE COORDINATION OF BENEFITS (COB) SECURE WEB SITE

You must read and accept the terms and conditions contained in this User Agreement expressly set out below and incorporated by reference before you may access the COB Secure Web site.

The CMS may amend this User Agreement at any time. Except as stated below, all amended terms shall automatically be effective 30 days after they are initially posted on the Site. This User Agreement is effective immediately.

1. Purpose of Section 111 Secure Web site

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), adds new Medicare Secondary Payer (MSP) mandatory reporting requirements for group health plan (GHP) arrangements and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation. The new provisions for GHP arrangements can be found at 42 U.S.C. 1395y(b)(7) and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation at 42 U.S.C. 1395y(b)(8). The purpose of the Section 111 MSP reporting process is to enable CMS to correctly pay for Medicare covered items and services furnished to Medicare beneficiaries by determining primary versus secondary payer responsibility. Section 111 responsible reporting entities may use the Section 111 COB Secure Web site to submit files for Section 111 MSP reporting. Additionally, this application will also provide a means for responsible reporting entities to review the status of current file submissions and statistical information related to historical submissions.

2. Privacy Policy

The U.S. Department of Health and Human Services (HHS) at (http://www.hhs.gov/), of which the CMS COB Secure Web site is a part, has a clear privacy policy. When you access the COB Secure Web site, we collect the minimum amount of information about you necessary to manage your account.

Information Automatically Collected and Stored

When you browse through any Web site, certain personal information about you can be collected. We automatically collect and temporarily store the following information about your visit:

- the name of the domain you use to access the Internet (for example, aol.com, if you are using an American Online account, or stanford.edu, if you are connecting from Stanford University's domain);
- the date and time of your visit;
- the pages you visited; and
- the address of the Web site you came from when you came to visit.

This information is used for statistical purposes only and to help us make this site more useful to visitors. Unless it is specifically stated otherwise, no additional information will be collected about you.

Information Collected through the COB Secure Web site

The personal information you provide is encrypted and sent to us using a secure method, in order to assure that your personal information is securely and safely transmitted. However, no one can give an absolute assurance that information intended to be maintained as private, whether transmitted via the Internet or otherwise, cannot be accessed inappropriately or unlawfully by third parties. We have taken and will continue to take reasonable steps to ensure the secure and safe transmission of your personal information.

Personally Provided Information

If you are not responsible for the MMSEA Section 111 MSP mandatory reporting using the COB Secure Web site, you do not have to give us personal information. If you choose to provide us with additional information about yourself through e-mail, forms, surveys, etc., we will maintain the information as long as needed to respond to your question or to fulfill the stated purpose of the communication.

Disclosure

HHS and CMS do not disclose, give, sell or transfer any personal information about its visitors, unless required for law enforcement or statute.

Intrusion Detection

The U.S. Government maintains the Web site. It is protected by various provisions of Section 1862(b) of the Social Security Act (42 USC 1395y(b)(5)), Publication 1075 of the Department of Treasury, Internal Revenue Service, and Title 18, U.S. Code. Violations of Title 18 are subject to criminal prosecution in federal court.

For site security purposes and to ensure that this service remains available to all Users, we employ software programs to monitor traffic to identify unauthorized attempts to upload or change information, or otherwise cause damage. In the event of authorized law enforcement investigations, and pursuant to any required legal process, information from these sources may be used to help identify an individual.

3. Systems of Records

Information originally collected in traditional paper systems can be submitted electronically, i.e., electronic commerce transactions and information updates about eligibility benefits. Electronically submitted information is maintained and destroyed pursuant to the Federal Records Act and in some cases may be subject to the Privacy Act. If information that you submit is to be used in a Privacy Act system of records, there will be a Privacy Act Notice provided.

4. Links

References from this Web site to any non-governmental entity, product, service or information do not imply endorsement or recommendation by the CMS, the HHS or any other HHS agency or employees

We are not responsible for the contents of any "off-site" Web pages referenced from this server. We do not endorse ANY specific products or services provided by public or private organizations. In addition, we do not necessarily endorse the views expressed by such sites, nor do we warrant the validity of any site's information or its fitness for any particular purpose.

5. Pop-up Advertisements

When visiting our web site, your web browser may produce pop-up advertisements. These advertisements were most likely produced by other web sites you visited or by third party software installed on your computer. The CMS does not endorse or recommend products or services for which you may view a pop-up advertisement on your computer screen while visiting our site.

6. Out-dated Information

Many HHS/CMS documents are time sensitive. Department policies change over time. Information in older documents may be out-dated. You also may wish to review our Privacy Policy, above.

7. Accessibility

This page provides information for those visitors who use assistive or other devices to access the content on this Web site. Please see our Contact section at http://cms.hhs.gov/contact/default.htm if you have general questions and comments or have difficulty finding something on this site.

Synopsis of Section 508 Accessibility Requirements

Section 508 requires that individuals with disabilities, who are members of the public seeking information or services from this Web site have access to and use of information and data that is comparable to that provided to the public who are not individuals with disabilities, unless an undue burden would be imposed on us. Section 508 also requires us to ensure that Federal employees with disabilities have access to and use of information and data that is comparable to the access to and use of information and data by Federal employees who are not individuals with disabilities, unless an undue burden would be imposed on us. (To learn more about the regulations governing the accessibility of Federal electronic information, read the Synopsis of Section 508 Accessibility Requirements at http://www.section508.gov/index8. Freedom of Information Act (FOIA)

The CMS COB Secure Web site is a service of the U.S. Department of Health and Human Services at http://www.hhs.gov/. Any Freedom of Information Act (FOIA) requests concerning this Web site should be submitted in accordance with the Department's FOIA guidelines, which are online at http://www.hhs.gov/foia. Information on making FOIA requests is available at the Freedom of Information Group page. You also may wish to review our Privacy Policy above.

8. 42 USC 1395y(b)(7) & (8)

(7) REQUIRED SUBMISSION OF INFORMATION BY GROUP HEALTH PLANS

(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 1 year after the date of the enactment of this paragraph, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan

administrator or fiduciary, shall

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this title; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) ENFORCEMENT

(i) IN GENERAL- An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.
(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1817.

(C) SHARING OF INFORMATION- Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary--

(i) shall share information on entitlement under Part A and enrollment under Part B under this title with entities, plan administrators, and fiduciaries described in subparagraph (A);
(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and
(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS

(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) REQUIRED INFORMATION- The information described in this subparagraph is

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and
(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

(C) TIMING- Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) CLAIMANT- - For purposes of subparagraph (A), the term `claimant' includes

(i) an individual filing a claim directly against the applicable plan; and
(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) ENFORCEMENT

(i) IN GENERAL- An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.
(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) APPLICABLE PLAN - In this paragraph, the term `applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or

administrator for such law, plan, or arrangement:

(i)Liability insurance (including self-insurance).
(ii) No fault insurance.
(iii) Workers' compensation laws or plans.

(G) SHARING OF INFORMATION- The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(H) IMPLEMENTATION - Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.'

(b) Rule of Construction- Nothing in the amendments made by this section shall be construed to limit the authority of the Secretary of Health and Human Services to collect information to carry out Medicare secondary payer provisions under title XVIII of the Social Security Act, including under parts C and D of such title.
(c) Implementation- For purposes of implementing paragraphs (7) and (8) of section 1862(b) of the Social Security Act, as added by subsection (a), to ensure appropriate payments under title XVIII of such Act, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportions as the Secretary determines appropriate, of $35,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2008, 2009, and 2010.

Privacy Act Statement

The collection of this information is authorized by 42 U.S.C. 1395y(b)(7) & (8). The information collected will be used to identify and recover past mistaken Medicare primary payments and to prevent Medicare from making mistakes in the future for those Medicare Secondary Payer situations that continue to exist.

SAFEGUARDING & LIMITING ACCESS TO EXCHANGED DATA

I agree to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged for the purposes of complying with the Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. § 1306], Section

1874(b) of the Social Security Act [42 U.S.C. § 1395k(b)], Section 1862(b) of the Social Security Act [42 U.S.C. § 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. § 552a]. The Responsible Reporting Entity shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by CMS. I agree that the authorized representatives of CMS shall be granted access to premises where the Medicare data is being kept for the purpose of inspecting security arrangements confirming whether the Responsible Reporting Entity is in compliance with the security requirements specified above. Access to the records matched and to any records created by the matching process shall be restricted to authorized CMS and Responsible Reporting Entity employees, agents and officials who require access to perform their official duties in accordance with the uses of the information as authorized under Section 111 of the MMSEA of 2007. Such personnel shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.

Welcome to Connecticut Judicial Branch E-Services

The Judicial Branch offers various electronic services, including electronic filing in civil and small claims matters, electronic short calendar markings entry and history, and online attorney registration, to further its mission to serve the interests of justice and the public by resolving matters brought before it in a fair, timely, efficient and open manner.

09/19/13 - Prior to July 1, 2013, funds to pay for service fees had been appropriated as other expenses in the Judicial Branch's portion of the state budget, but were removed by the Appropriations Committee and reflected in the Branch appropriations in Public Act 13-247. In accordance with legislative intent, effective July 1, 2013, the Judicial Branch may no longer absorb the service fee associated with all (in-person and Internet) credit card transactions. Therefore, effective September 20, 2013, and going forward, filers who are using a credit card (MasterCard, Visa, American Express and Discover) to pay electronically for court fees through civil e-filing will be charged the service fee in accordance with C.G.S. 51-193b. It is currently set at the greater of $1.00 or 2.2% of the total amount owed. The amount of any such fee will be clearly disclosed to the payer prior to completion of the transaction. The service fee will be collected and retained by LexisNexis, the payment processor for

Self-Represented Parties and Attorneys

Self-Represented Parties and Attorneys

Please send any questions, comments or suggestions about e-filing, short calendar markings or any other aspect of E-Services to eservices@jud.ct.gov.

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09/12/13 -- A service fee is charged for payments of court fees or other payments to the court made by credit card. Beginning in mid-September, filers who are using a credit card (MasterCard, Visa, American Express and Discover) to pay electronically for court fees through civil e-filing will be charged this service fee. It is currently set at the greater of $1.00 or 2.2% of the total amount owed. The service fee will be collected and retained by LexisNexis, the payment processor for these transactions. In the coming months, the service fee will also be added to payments of court fees or other payments to the court made by credit card at the local courthouses.

08/28/13 -- E-mail Updates is a new option that allows people to sign up (subscribe) to receive automatic e-mail updates from the Judicial Branch when activity has taken place on any civil or family case that has public information available on the Judicial Branch website. More information on e-mail updates and a guide on how to sign up to receive e-mail updates on a case.

08/15/13 -- Beginning August 20, 2013, each time you upload a document you are electronically filing with the court, you must check a box to confirm that you have reviewed the document to make sure that it does not include any personal identifying information unless it is otherwise required by law or order of the court.

Personal identifying information is defined in section 4-7 of the Connecticut Practice Book, and it includes:

- a person's date of birth;
- mother's maiden name;
- Social Security number; or
- any financial account number, security code or personal identification number (PIN).

07/01/13 -- The Small Claims E-Filing site will shut down at 5:00 p.m. on Friday, July 12, 2013 and will be unavailable until 7:00 a.m. on Monday July 15, 2013 to allow for an upgrade. *All items in the Small Claims E-Filing shopping cart, must be filed and paid for before 4:55 p.m. on July 12, 2013.* All items remaining in the shopping cart when the system is shut down will be removed, and you will have to re-enter the information after the upgrade on Monday morning.

05/16/13 -- Changes are being made to E-Services, **effective May 18, 2013**. These changes include the reorganization of the E-Services menu options, the implementation of Self-Represented Party e-filing, and several enhancements to the site, such as the ability to retrieve a confirmation page through My E-Filed Items and the listing of all cases with recent activity on the Civil/Family Menu page. For more information, please see the PDF Overview of E-Services Enhancements and Changes.

03/28/13 - Changes to Document Titles (Legend Codes) for Civil E-filing

01/30/13 - The Procedures and Technical Standards for E-Services have been revised to clarify a change in the short calendar marking procedures for particular motions that appear as non-arguable on the property calendar. The changes in the documents are highlighted for your convenience.

12/13/12 - The Procedures and Technical Standards for E-Services have been revised to reflect a change in the short calendar marking procedures. The changes in the documents are highlighted for your convenience.

10/10/12 - Counsel and self-represented parties are advised that as a result of delays in mail delivery caused by changes in US Postal Service mail-processing, the office of the chief court administrator has directed that the printing, uploading and mailing of the Monday short calendars will occur two days earlier than it does currently to ensure timely delivery to all parties. For more information on the calendars that are affected and the impact of the changed date on filings, see the full text of the notice: Changes to the Date for Filing Motions and Objections for Monday Short Calendars - PDF

09/21/12 - Case lists for attorneys and firms can now be filtered to display pending and disposed cases, pending cases only, or disposed cases only. Case lists also display a "New!" icon next to cases with recent activity: a red icon indicates activity in the past one or two days; a green icon indicates activity in the past two weeks. The lists can be sorted by "Latest Activity" to display the cases in order of the latest activity. These enhancements were suggested by members of the bar and legal support staff at focus groups held earlier this year.

09/19/12 - Beginning 9/24/12, the Juvenile CMIS docket will be available to attorneys, prosecutors and public defenders through E-Services. Log-in to E-Services with juris number, password and agreement to specified confidentiality terms is required for access.

09/12/12 - Beginning Thursday, September 13, 2012, attorneys will now access the Child Protection Docket through the link "Juvenile Matters" after logging into E-Services. After clicking on "Juvenile Matters", the link "CP Docket Access" will then be available.

(Foreclosure Calendar) will not be scheduled for the Judicial District of Danbury on Monday, July 30, 2012 or on Monday, August 6, 2012. All other short calendars will take place.

06/25/12--Changes to court fees are going into effect on July 1, 2012 as a result of Public Act 12-89. The new fees will be charged for any documents with a **file date of July 1, 2012**. If you file and pay for documents after **5:00 PM on Friday, June 29, 2012**, you will be charged the new filing fee. The new fee schedule can be found on the Court Fees page of the website.

05/11/12--Changes will be made to the scheduling of the civil and family short calendars and marking periods and to the Family Support Magistrate Calendars for the period from June 25, 2012 to July 9, 2012. These temporary changes will permit the Judicial Branch to implement a significant system upgrade. Please see more information: Notice Regarding Short Calendar Schedule Changes - PDF

Effective Monday 4/2/12, Child Protection dockets will be available to child protection attorneys and other authorized users through E-Services. Log-in to E-Services with juris number and password and agreement to specified confidentiality terms is required for access. If you have any questions, please contact us.

02/27/12--Focus groups on electronic filing (e-filing) for attorneys, paralegals, legal assistants and legal support staff are scheduled on February 28, 2012 at 5:30 PM at the Superior Court, 1 Lafayette Circle, Bridgeport, CT and on March 1, 2012 at 5:30 PM at the offices of Superior Court Operations, 225 Spring Street, Wethersfield, CT. If you are interested in participating in one of these focus groups or if you have any questions, please contact Alice Mastrony at (860) 706-5321 or by email at alice.mastrony@jud.ct.gov.

01/31/12--Although access from foreign IP addresses is generally blocked, an attorney traveling overseas can obtain access for a specific IP address on a temporary basis. To obtain temporary access to the E-Services site to file or view documents or mark short calendar matters from a foreign IP address, contact the Judicial Branch HelpDesk at (860) 282-6555 or by email at helpdesk@jud.ct.gov. Provide the HelpDesk with the dates when you will need access and your IP address. To find your IP address, you may click on the following link: http://whatismyipaddress.com/.

01/19/12--The Judicial Branch will be increasing electronic access to court files for the public in the coming year. Therefore, it is extremely important that counsel and self-represented parties remove, black-out or redact personal identifying information from any documents or attachments filed with the court in civil, family or small claims matters unless the law or a court order requires that it be filed. Not removing, blacking out, or redacting personal identifying information could result in penalties or sanctions being ordered by the court or in the personal liability of the filer. See Practice Book § 4-7.

01/01/12--Notice Regarding 2012 Attorney Registration

E-Services Quick Reference Guide

Questions?

E-Services Help Line: (860) 765-4452 or
Eservices@jud.ct.gov
Alice Mastrony (860) 706-5321 or (860) 573-6411
alice.mastrony@jud.ct.gov

Before using **E-Services**, review the Procedures and Technical Standards for E-Services, which apply to all electronic services of the Judicial Branch, including e-filing and online short calendar markings. It is available from the Getting Started tab at the top of the E-Services Welcome Page, which can be accessed by clicking on the **E-Services** link on the home page. This guide provides a brief summary of the main functions available through E-Services.

Signing Up for E-services

- Go to the Judicial Branch home page by entering www.jud.ct.gov in the Address bar.
- To check your current address, from the Judicial Branch home page go to Attorney/Firm Inquiry and enter your juris number, last name, or firm name.
- If your address online is not accurate, you must notify the Statewide Grievance Committee of your new address by U.S. Mail by completing and mailing form JD-GC-10 *before you can enroll.*

Note: If the address displayed on the website reads "Address not available," it means that the home address is on file, and it is not displayed for security reasons.

- Click on **E-Services** on the left of the home page.
- Click the **Enroll** button for **Attorney** or **Self-Represented Party**.
- Complete the form and print a copy of it before you click **Submit**.
- Confirm your email address by clicking **OK** and a message confirming your enrollment will appear.
- If you are enrolling as an attorney or law firm, within five to seven business days, you will receive your password by U.S. Mail at the address on file.
- If you are enrolling as a self-represented party, you will receive an email that provides you with a link to validate your account.
- To update your email address or telephone number, select **Change Enrollment Information** from the E-Services menu.

Annual Attorney Registration with the Statewide Grievance Committee

- After logging in to E-Services, click on **Attorney Registration** from the menu on the left side of the E-Services home page.
- Fill in the requested information, making sure to select "Yes" to certify that your information is accurate.
- Click **Save Data** or **Submit** to complete your registration.
- You may print a copy of the online form for use in obtaining a certificate of good standing.
- To change information in your registration, click on **Attorney Change of Information** from the E-Services menu.

Note: Name changes and corrections of birth dates must be submitted in hard copy, with proof of the changes or corrections, to the Statewide Grievance Committee, 287 Main St., 2nd Fl., Suite 2, East Hartford, CT 06118-1118.

Client Security Fund Fee Payment

Payment of the annual Client Security Fund fee may be made by electronic check through E-Services. Credit card payments are not accepted online. Information about the fee and payment is available on the E-Services Welcome Page under the Attorney Regulation tab.

- After logging in to E-Services, select **Client Security Fund Fee** from the E-Services menu.
- Enter the juris number for which payment is to be made and Click **Submit**.
- Select whether you are paying the full fee, claiming a partial exemption or claiming a full exemption, and click **Submit**.
- Click **Yes** if you are submitting payments for additional juris numbers. You are limited to twenty (20) transactions per check.
- Select **Pay by Check**
- Fill in the required information and click **Process Payment**
- Click **Print Confirmation** to print your payment summary.
- For questions about the Client Security Fund fee, contact [illegible] or call (860) 568-3450.

Attorney Advertising

- Attorney advertisements must be submitted electronically to the **Statewide Grievance Committee**. (P.B. Sec. 2-28A)
- Log in under your **individual** juris number and click on **Attorney Advertisement** from the **E-Services** menu.
- Submit the information and advertisement in accordance with the instructions.
- Information about the attorney advertising is available on the E-Services Welcome Page under the Attorney Regulation tab.
- For questions about attorney advertising, contact Statewide Grievance (860) 568-5157 or at attorney.advertising@jud.ct.gov

Foreclosure Sales

The Foreclosure Ad Posting function is available only to attorneys who have been appointed as a Committee upon the entry of a Judgment of Foreclosure By Sale. Each attorney is only allowed to serve as Committee in one Judicial District; the appointment being an individual appointment, not a firm appointment. An individual appearance for the "Committee" must be filed in order to access the Foreclosure Ad Posting function. Click on the How Do I? tab at the top of the E-Services Welcome Page and select "Post or Edit a Foreclosure Advertisement" for more information.

Appellate Briefs

Section 67-2 (K) of the Rules of Appellate Procedure requires parties represented by counsel to submit briefs electronically in cases to be argued in the Supreme Court. This feature allows those submissions. Note: The electronic submission requirement in subsection (K) does not eliminate the need to file paper copies of briefs. Click on the Supreme/Appellate tab at the top of the E-Services Welcome Page for additional information.

Online Short Calendar Markings

Attorneys and law firms must submit short calendar markings electronically through E-Services for Civil and Family matters. Matters must be marked in accordance with the procedures set forth in the **Notice** section of the respective calendars and in accordance with the Civil **and** Family **Short Calendar Standing Orders**, which include the time frames for submitting markings.

Note: Self-represented parties, and attorneys or law firms with an exclusion from E-Services requirements, mark their cases by telephone by calling the marking line that is printed on the notice received about the calendar. Markings by facsimile are not accepted.

- Go to www.jud.ct.gov and log in to E-Services.
- Select **Short Calendar Markings Entry** from the menu on the E-Services home page.
- To view markings history, calendars by juris number, or calendar notices, select the tab from the top of the page.

- Select the **Location** and **Court Type**
- Select **Sort Results** to display cases by case name, docket number, location, entry number, calendar sequence number or motion

Click **Search**

Note: Motions or objections display separately so if a case has multiple motions or objections, the caption and docket number will appear multiple times. Each one must be marked separately.

- To mark civil matters, select **Ready, Take Papers** or **Off;** for family matters, select **Ready** or **Off.**

Note: Be sure to follow the instructions on the calendar notice.

- Check the certification box.
- Enter the name and telephone number of the individual submitting the markings.
- Click **Enter Markings** and print the *Short Calendar Markings Confirmation and Receipt.*
- Provide notice of marking to all appearing parties.

Note: If you mark an arguable matter ready, you must bring the confirmation of the marking to the short calendar hearing.

- Information about the marking short calendar matter is available by selecting "Mark Short Calendars" on the **E-Services Welcome Page** under the **How Do I?** tab.

Note: Markings submitted electronically are viewable online during the marking period. Markings history is available through E-Services. Telephone markings will not appear online or in the markings history.

For questions about short calendar markings, contact eservices@jud.ct.gov or call the E-Support Line at (866) 765-4452.

Designated Filers and Case Initiations

Attorneys registered with the Statewide Grievance Committee and law firms that have obtained a law firm juris number may designate authorized individuals to file case initiation documents on their behalf. A designated filer will have a UserID and a password for use in accessing E-Services to maintain the designated filer's account and to file case initiation documents electronically in the Superior Court on behalf of the attorney or law firm.

Any electronic transactions conducted by a designated filer will be presumed to have been authorized by the attorney and/or law firm whose juris number was used by the designated filer to conduct the electronic transaction.

A complete quick reference guide on designated filers is available at caseflow offices and court service centers and on-line under E-Services at www.jud.ct.gov.

Electronic Filing (e-filing)

E-filing of *all civil* case types, with some exceptions, is mandatory for attorneys and firms without an exclusion from E-Services requirements. To view the exceptions to mandatory e-filing, see the revised Procedures and Technical Standards for E-Services. Documents in all e-filable cases must be filed electronically. E-filable cases have docket numbers beginning with a or a . (For example, HHD CV 12 013147). Quick reference guides are available at caseflow offices and court service centers and on-line under E-Services at www.jud.ct.gov.

Note: Use of the electronic filing system is limited to (1) enrolled attorneys and law firms and the employees of the law office under the supervision of an enrolled attorney and (2) individuals designated by attorneys and law firms to file case initiation documents on their behalf.

E-File an Appearance

- Click on **Select Case** or **Party Search** from the **Civil EFiling** menu bar to locate the case.
- Fill in the requested information; **Click Here** to arrive at the **Case Detail** screen.
- Select **E-File an Appearance** as the case activity; click **Go**.
- Fill in the requested information; select "yes" to indicate that you will accept certification by email rather than U.S. Mail or fax;
- Click **Continue.**
- Review the appearance that displays;
- Print or save the document. You do not create this form; the e-filing system creates it.
- A **Confirmation Screen** displays once the document has been successfully e-filed. Print this screen or save it electronically.

Note: You must send opposing parties copies of your e-filed documents, pleadings and motions in accordance with Practice Book rules.

E-Services Procedures and Technical Standards

I. General Provisions

A. **Scope/Authority** – These revised E-Services Procedures and Technical Standards have been issued by the Honorable Barbara M. Quinn, Chief Court Administrator under the authority of Section 4-4 of the Connecticut Practice Book, to become effective on September 20, 2013. They apply to all electronic services offered by the Judicial Branch. Specific procedures that apply to facsimile filing, e-filing, short calendar markings, small claims, and electronic citations (eCitations) are set forth in subsequent sections of these procedures and technical standards.

B. **Technical/System Requirements and Security** –

1. The hardware and software requirements for participation in E-Services are as follows:

   a. A personal computer with a 128-bit encryption version of Microsoft Internet Explorer® version 6 or higher, or Firefox 3.0 or higher;
   b. Internet access (DSL or high speed Internet access is suggested for Civil e-filing); and
   c. Adobe Acrobat® Reader ® 5.0 through 9.0 for PDF document creation and Adobe Acrobat® Reader ® 5.0 or higher for viewing documents.

2. It is the responsibility of the users to review the Minimum Browser Requirements for Electronic Services to determine if their browser is compatible with the Judicial Branch's security requirements and to access links allowing users, without costs, to upgrade their browsers or download a high-security browser.

3. The Judicial Branch has adopted encrypted security and firewall protective measures to safeguard information transmitted through electronic transactions from loss, misuse, or alteration from outside influences. The use of security software and a security certificate on the Branch's web site establishes a direct Secure Sockets Layer (SSL) connection between the user's computer and the Electronic Services section of the Branch's web site. This connection automatically encrypts the transaction and prevents others from viewing the transaction.

Note: Microsoft Internet Explorer® is a trademark of Microsoft Corporation, and Adobe Acrobat® Reader ® is a trademark of Adobe Systems Incorporated.

C. **Enrollment and Passwords** –

1. Attorneys registered with the Statewide Grievance Committee and law firms which have obtained a law firm juris number must enroll and obtain a secure password that will enable them to access and complete transactions electronically with the Court. In order to ensure an attorney/law firm's authentication as the valid user of a juris number, upon enrollment in E-

Services, an initial password will be issued and mailed to the enrolling attorney at the office address that is registered with the Statewide Grievance Committee and to the enrolling law firm at the address of record with its law firm juris number.

Attorneys permitted to appear pro hac vice cannot enroll in E-Services, file electronically or mark short calendar matters electronically.

Attorneys registered with the Statewide Grievance Committee and law firms which have obtained a law firm juris number may designate authorized individuals to file case initiation documents on their behalf. A designated filer will have a UserID and password for use in accessing E-Services to maintain the designated filer's account and to file case initiation documents electronically with the Court on behalf of the attorney or law firm.

2. Self-Represented Parties must enroll in E-Services and choose a user ID and secure password that will allow them to access and complete transactions electronically with the Court. To make sure that a self-represented party is the valid user of the User ID, an email will be sent to the user at the email address given by the self-represented party when he or she enrolled. That email will contain a link to a secure page where the user will verify the account information and activate the account.

   a. For filing electronically in small claims matters, Self-Represented Parties must have enrolled in E-Services and activated their account.

   b. For filing electronically in Superior Court matters, Self-Represented Parties must:

      (1) Enroll in E-Services and activate their account
      (2) Request and be approved for electronic access by the clerk in any case that they did not initiate electronically.

Note: Use of the electronic filing system is limited to (1) enrolled attorneys and law firms and the employees of the law office under the supervision of an enrolled attorney; (2) individuals designated by attorneys and law firms to file case initiation documents on their behalf; and (3) enrolled self-represented parties who have activated their account and, as required, been approved for electronic access to a case.

It is the responsibility of the attorneys, law firms, and self-represented parties to protect passwords and security information from any unauthorized use. Any electronic transactions transmitted shall be presumed to have been authorized by the attorney, law firm or self-represented party whose user ID or juris number and password were used to conduct the electronic transaction on the Judicial Branch web site. Any electronic transactions conducted by a designated filer shall be presumed to have been authorized by the attorney and/or law firm whose juris number was used together with the password of the designated filer to log in to E-Services to conduct the electronic transaction.

If any E-Services system users believe that their security information and password have been compromised or are being used by unauthorized individuals, the user must immediately contact the Judicial Branch IT Division HelpDesk at (860)-282-6555 or at HelpDesk@jud.ct.gov.

The Office of the Chief Court Administrator reserves the right to suspend any password and terminate the access of any user who, in the opinion of the Branch, misuses any electronic services.

D. **Obtaining an Exclusion** – Attorneys and law firms can apply for an exclusion from electronic services requirements by completing the Request for Exclusion from Electronic Services Requirements form (JD-CL-92). The form shall be submitted to the E-Services Exclusion Requests, Superior Court Operations, 90 Washington Street, 3rd Floor, Hartford, CT 06106 for processing. Each exclusion request shall be ruled on by the Chief Court Administrator or the Chief Court Administrator's designee.

E. **Signatures** –

1. The following applies to documents filed by attorneys, designated filers, and self-represented parties:

   a. A document that is submitted electronically through the e-filing system or that is submitted electronically through facsimile must be signed by the attorney submitting the document as follows:

      (1) For any document electronically filed in the e-filing system, entry in the e-filing system of the individual juris number of the attorney who electronically filed the document will constitute the signature of the attorney for the purposes of Section 4-2, Section 10-14 and Section 24-8 of the Practice Book.

      (2) For any document that is filed by facsimile, the attorney must include the individual juris number, typed name, a facsimile of an actual signature, or a pen-to-paper signature on the signature lines of the document before faxing the document to court. The placement, on the signature lines, of the individual juris number, typed name, facsimile of an actual signature, or pen-to-paper signature will constitute the signature of that attorney for the purposes of both Section 4-2 and Section 10-14 of the Practice Book.

   b. Any document electronically filed by a designated filer on behalf of an attorney or law firm as part of the return of case initiation documents must contain the individual juris number and typed name of the attorney, and must be signed and fully executed in writing before the conversion of the documents to an electronic image and the electronic filing of the documents.

   c. A document that is submitted by a self-represented party electronically through the e-filing system or that is submitted

electronically through facsimile must be signed by the self-represented party as follows:

(1) For any document electronically filed with the Superior Court through the e-filing system, entry in the e-filing system of the User ID of the self-represented party who electronically filed the document will constitute the signature of the self-represented party for the purposes of Section 4-2 and Section 10-14.

(2) Case initiation documents and any other document requiring oath or affirmation filed with the small claims court through small claims e-filing must be signed and fully executed in writing with a pen-to-paper signature on the signature lines of the document before the documents are electronically filed. The placement on the signatures lines of the pen-to-paper signature shall constitute the signature of the self-represented party.

(3) For all other documents electronically filed with the small claims court through small claims e-filing, entry in the small claims e-filing system of the User ID of the self-represented party who electronically filed the document will constitute the signature of the self-represented party.

(4) For any document that is filed by facsimile, the self-represented party must sign with a pen-to-paper signature on the signature lines of the document prior to filing with the court. The placement on the signature lines of the pen-to-paper signature shall constitute the signature of the self-represented party for the purposes of both Section 4-2 and Section 10-14 of the Practice Book.

d. Documents signed in accordance with this section will have the same validity and status as a paper document that was signed or verified by the attorney, designated filer or self-represented party,

2. The following applies to documents issued by the Superior Court or by a judge, judge trial referee or family support magistrate of the Superior Court, or by a magistrate appointed under section 51-193*l* of the Connecticut General Statutes, or to any notice, order, decision, execution, process or other document issued by a chief clerk, deputy chief clerk, clerk, deputy clerk, assistant clerk, temporary assistant clerk, caseflow coordinator, administrative clerk, clerical assistant or administrative assistant of the Superior Court under sections 51-52, 51-52a or any other section that authorizes the issuance of documents by a chief clerk, deputy chief clerk, clerk, deputy clerk, assistant clerk, temporary assistant clerk, caseflow coordinator, administrative clerk, clerical assistant or administrative assistant, or by a support enforcement officer under subsection (s) of section 46b-231 or any other section that authorizes the issuance of documents by a support enforcement officer.

a. A document issued by the Superior Court or by a judge, judge trial referee or family support magistrate of the Superior Court, or by a magistrate appointed under section 51-193*l*, including any notice, order, judgment, decision, decree, memorandum, ruling, opinion, mittimus or similar document, may be signed or verified by the electronic entry of the juris number of the signing authority on the signature line of the notice, order, judgment, decision, decree, memorandum, ruling, opinion, mittimus or similar document and the electronic entry of the name of the signing authority on the document.

b. A document, including any notice, order, decision, execution, process or other document, issued by a chief clerk, deputy chief clerk, clerk, deputy clerk, assistant clerk, temporary assistant clerk, caseflow coordinator, administrative clerk, clerical assistant or administrative assistant of the Superior Court under sections 51-52, 51-52a or any other section that authorizes the issuance of documents by a chief clerk, deputy chief clerk, clerk, deputy clerk, assistant clerk, temporary assistant clerk, caseflow coordinator, administrative clerk, clerical assistant or administrative assistant, or by a support enforcement officer under subsection (s) of section 46b-231 or any other section that authorizes the issuance of documents by a support enforcement officer may be signed or verified by the electronic entry of a "By the Clerk" juris number or a "By the Support Enforcement Officer" juris number on the signature line of the notice, order, decision, execution, process or other document, and the electronic entry of the name of the person logged in to the computer, which cannot be changed by the user of the computer, and must be the name of the signer of the document. No transactions can be processed by a user under another person's name.

c. Documents signed in accordance with this section will have the same validity and status as a paper document that was signed or verified by the Superior Court or by a judge, judge trial referee or family support magistrate of the Superior Court, a magistrate appointed under section 51-*193l,* a chief clerk, deputy chief clerk, clerk, deputy clerk, assistant clerk, temporary assistant clerk, caseflow coordinator, administrative clerk, clerical assistant or administrative assistant, or support enforcement officer.

3. A document that has been prepared and signed electronically by a law enforcement officer or agency or that has been prepared electronically by a law enforcement agency and that has been signed electronically by a person other than a law enforcement officer and that is filed in paper format must be signed electronically in accordance with the Law Enforcement Electronic Signature Procedures and Technical Standards.

Note: Requirements regarding the filing of affidavits and other documents requiring an oath or affirmation as well as certain other documents are discussed

in the sections on Electronic Filing (e-filing), Small Claims e-filing and Facsimile Filing that follow.

F. **Payment** –

1. Attorneys, law firms or designated filers - Payment of court fees and any applicable service fees by credit card or by electronic check must be made at the time of filing. Filers are required, as part of the payment process, to certify that, by entering the bank account and routing number or by entering the credit card account information and submitting the payment, they are authorized to permit the Connecticut Judicial Branch to debit or charge the account for the amount(s) indicated.

2. Self-represented Parties – Payment of court fees and any applicable service fees can be made only by credit card. Any payment must be made at the time of filing. Filers are required, as part of the payment process, to certify that, by entering the credit card account information and submitting the payment, they are authorized to permit the Connecticut Judicial Branch to charge the account for the amount(s) indicated.

G. **Official file** – For all e-filable cases with a return date of December 31, 2009 and earlier, the paper file is the official file.

1. For all e-filable cases with a return date on or after January 1, 2010, the electronic file is the official court file. The electronic image that resides in the court's electronic filing database, whether filed electronically or filed in paper format and scanned into an electronic image and placed in the electronic file by the clerk, will be deemed to be the original.

2. For all small claims cases, the paper file is the official file.

H. **System Availability** - In general, **electronic services are available from 7:00 AM through 3:30 AM.** The hours between 3:30 AM and 7:00 AM are used for system maintenance and updating. The system may also be offline on the fourth Saturday of the month between 7:00 AM and 3:00 PM for routine system maintenance. If the system requires a scheduled outage, the Judicial Branch will make every effort to issue a prior announcement on the Branch's web site. In the event of an outage, it is the Branch's business continuity policy that parties, attorneys, and law firms conduct business with the courts in accordance with the Connecticut Practice Book or other court orders.

In accordance with Connecticut Practice Book section 7-17, if a party is unable to electronically file a document because the court's electronic filing system is non-operational for 30 consecutive minutes from 9 o'clock in the morning to 3 o'clock in the afternoon or for any period of time from 3 o'clock to 5 o'clock in the afternoon of the day on which the electronic filing is attempted, and such day is the last day for filing the document, the document shall be deemed to be timely filed if received by the clerk's office on the next business day the electronic system is operational.

A document that is electronically received by the clerk's office for filing after 5:00 PM on a day on which the clerk's office is open or that is electronically received by the clerk's office for filing at any time on a day on which the clerk's office is closed shall be deemed filed on the next business day on which such office is open. (See also Section II.F. of these Procedures and Technical Standards.)

The hours for submitting short calendar markings online are governed by the Civil or Family Short Calendar Standing Order.

I. **Retention and Destruction of Files and Records** – The provisions of Practice Book Sections 7-10 through 7-16 concerning the retention and destruction of court files are applicable to electronic files and records.

J. **Modifications to standards and procedures** – The Judicial Branch reserves the right to add to, modify, or delete any section of these procedures and technical standards, including but not limited to the electronic transactions, at any time without notice. Additionally, these procedures and technical standards will be updated as necessary to incorporate any changes or additions to the available electronic services. It is, therefore, suggested that attorneys and law firms review these procedures and technical standards periodically. Accessing electronic services after any additions, modifications, or deletions have been made will constitute the acceptance of such changes on the part of the user.

K. **Privacy Policy** – The Judicial Branch has posted a PRIVACY POLICY which should be reviewed.

L. **Proprietary Rights** – The State of Connecticut Judicial Branch web site is owned and operated by the Branch. All contents of the site, including but not limited to intellectual property, text, graphics, and other images, are the property of the Branch and are protected by U.S. copyright laws.

II. Electronic Filing (e-filing) – Civil Matters, except small claims actions

A. **Scope** –The following procedures are established by the Office of the Chief Court Administrator for the filing of motions, pleadings, or other documents by electronic means through the e-filing system under Section 4-4 of the Connecticut Practice Book. These procedures apply to all case types that are established as e-filable by the Judicial Branch. **Family cases are not e-filable at this time.**

There is a separate procedure for the e-filing of small claims actions. See Section III for specific information on electronic filing of small claims actions.

B. **Mandatory Electronic Filing and Exceptions -** Electronic filing in *all* existing and newly initiated civil cases of all motions, pleadings and documents, except those listed in the following subsections, is mandatory for all attorneys and law firms without an exclusion from electronic services requirements. It is not mandatory for Self-Represented Parties. The exceptions are:

1. The following cases cannot be initiated electronically, but subsequent motions, pleadings or documents are required to be filed electronically:

a. Cases that include a prejudgment remedy except for a prejudgment remedy based upon a **commercial waiver**;
b. Transfers from small claims; and
c. Eminent domain cases (including state highway condemnation and redevelopment condemnation).

2. Cases that are commenced by private individuals on behalf of the State of Connecticut under C.G.S. 17b-301d cannot be initiated electronically but motions, pleadings or documents filed subsequent to the statutorily required sealing period are required to be filed electronically in these cases.

3. The following cases cannot be initiated electronically, and subsequent motions, pleadings or documents cannot be filed electronically:

   a. Application for Proceeds from a Tax Sale
   b. Asset forfeitures;
   c. Firearm Safety Hearings (C.G.S. §29-38c)
   d. Foreign civil judgments (C.G.S. §§ 52-604, 52-605);
   e. Foreign protective orders;
   f. Habeas cases;
   g. Lottery Assignment cases;
   h. Proceedings for enforcement of municipal regulations and ordinances (C.G.S. §§ 7-152b and 7-152c, form JD-CV-20);
   i. Summary Process and Housing civil matters; and
   j. Vehicle forfeitures (pursuant to C.G.S. 22a-250 and 250a).

4. The following documents **cannot** be filed electronically and must be filed in paper format:

   a. Any document for which a fee waiver has been granted
   b. Appearance by a non-party
   c. Appearance by an attorney admitted pro hac vice
   d. Application for Order of Notice (pre-service)
   e. Application for Prejudgment Remedy (at case initiation or during a case)
   f. Appraisal Report of the disinterested appraiser (if filed by the appraiser with the court)
   g. Certificate of Judgment – Foreclosure by Sale (JD-CV-46)
   h. Certificate of Judgment – Strict Foreclosure (JD-CV-47)
   i. Committee Deed (original deed)
   j. Ex Parte Application for Permission to Use Pseudonyms
   k. Foreclosure Return of Sale – *with proceeds*
   l. Lodged Records (pursuant to Practice Book Sections 7-4B and 7-4C)
   m. Motion for Protective Order (on behalf of non-appearing witness)
   n. Motion to Appear Amicus Curiae
   o. Motion to be Made a Party (defendant or plaintiff)
   p. Motion to Close a Courtroom Proceeding
   q. Motion to Consolidate (filed by a non-party)
   r. Motion to Intervene
   s. Motion to Open in cases that may have been destroyed or stripped under Practice Book Sections 7-10 or 7-11

t. Motion/Application for Permission to Use Pseudonyms
u. Motion to Quash (on behalf of non-appearing witness)
v. Motion to Substitute Party/Executor (if filed by a non-party)
w. Motion/Application for Permission to Use Pseudonyms
x. Offer of judgment
y. Petition for Automatic Ninety-day Extension of Statute of Limitations (C.G.S. 52-190a (b))
z. Sealed Documents (any document that is sealed, for which sealing is requested, or documents filed during the statutorily required sealing period in actions commenced under C.G.S. 17b-301d)
aa. Any small claims documents other than those filed for case initiation.

When filing any document, the filer must include in the additional description field in the e-filing system the entry number (s) of any other documents relevant to the document being filed. For example, if filing an objection, the filer should include the entry number from the case detail screen for the motion or request to which the objection is addressed. When filing a Motion for Continuance, include the name and the date of the event for which you are seeking a continuance.

Note: It is the responsibility of each attorney or self-represented party who files a document electronically or in paper format to omit from the filing any confidential or otherwise privileged information unless the inclusion of such information is required by law, requested on a Judicial Branch form, or otherwise ordered by the Judicial Authority.

C. **Document destruction and retention by the Clerk -** Any document that is filed with the clerk in paper format (including faxed documents) after December 5, 2009 will be scanned by the clerk into an electronic image, and placed in the electronic file. Except for bonds, any original paper document will be destroyed unless the filer includes with the paper document at the time of filing a self-addressed, postage prepaid, return envelope. Bonds submitted in paper format will be scanned by the clerk into an electronic image and retained during the pendency of the case and any applicable appeal period. Fee waiver applications submitted in paper format will be scanned by the clerk into an electronic image and will be maintained in the e-filing system as viewable remotely by all counsel of record, and as viewable in court locations by self-represented parties, non-appearing parties, and the public.

D. All documents filed in paper format prior to December 5, 2009 in cases with a return date of December 31, 2009 or earlier shall be retained in that format as part of the court file and any provision of these procedures to the contrary shall not be applied.

E. **Filing Specific Types of Documents and Document Retention by the Filer –** The requirements in these E-Services Procedures and Technical Standards regarding when a paper document that has been electronically filed must be retained by the filer do not supersede or alter any other law, court order or policy requiring the filer to keep the paper document.

1. Case Initiation Documents

   a. After the service of a signed writ of summons and complaint, an attorney shall electronically file a true copy of such documents and the return of service with the clerk. For all cases initiated with a return date of December 31, 2009 and earlier, the filer shall retain the signed original paper documents throughout the pendency of the action, any appeal period, and any applicable appellate process. For cases initiated with a return date of January 1, 2010 and in the future, the signed original paper documents are not required to be retained by the filer.

   b. If the case initiation documents are filed by a designated filer authorized under Sec. I. C. of the Procedures and Technical Standards, the original signed writ of summons and complaint must be scanned into an electronic image and filed electronically with the clerk. For all cases initiated with a return date of December 31, 2009 and earlier, the attorney shall retain the signed original paper documents throughout the pendency of the action, any appeal period, and any applicable appellate process. For cases initiated with a return date of January 1, 2010 and in the future, the signed original paper documents are not required to be retained by the filer.

2. Return of Record – The Return of Record in an administrative appeal may be filed on paper at the option of the filer until further notice.

3. Documents requiring oath/affirmation or returns of service – Returns of service and documents that require an oath or affirmation once signed and fully executed in writing, are required to be scanned into an electronic image and filed electronically with the clerk. For all cases initiated with a return date of December 31, 2009 and earlier, the filing party shall retain the original paper documents throughout the pendency of the action, any appeal period, and any applicable appellate process. For cases initiated with a return date of January 1, 2010 and in the future, with the exception of a bond filed in any action, the signed original paper documents are not required to be retained by the filer.

4. Documents that have been redacted – If a document has been redacted, the filer must keep the original unredacted document throughout the pendency of the action, any appeal period, and any applicable appellate process under Section 4-7 (b) of the Connecticut Practice Book.

F. **Filing Date/Confirmation of Filing** – An electronically transmitted document shall be deemed filed when it is received by the clerk's office during the normal hours of operation of the office. A document that is received outside of the normal business hours, including a day on which the clerk's office is closed, shall be deemed filed on the next business day upon which such office is open. The time that a document is submitted and the time that such document is filed shall be recorded in the electronic filing database and shall be directly associated with the specific document. Confirmation of the date and time of an electronic transaction and of the filing date of the document filed electronically shall be transmitted electronically to the filer. It is recommended that the filer of the

document print out or electronically copy and retain such confirmation throughout the pendency of the action, any appeal period, and any applicable appellate process.

G. **Corrective Measures in E-Filing** - Clerk's office staff have the ability to perform either document substitution on attorney e-filed documents or repair on clerk scanned documents; move documents on clerk scanned documents; or conform data entry to the summons in electronically filed case initiations. The specific procedures are as follows.

1. Substitution - Where a technical problem (i.e. readability and/or legibility errors) exists with a document e-filed by an attorney, the attorney may seek a substitution of the document by way of a written Motion to Substitute. The "Proposed Document for Substitution" must be appended to a Motion to Substitute. The motion will be taken on the papers, but it will print on a calendar to allow other parties an opportunity to object to the granting of the motion.

   If the Motion to Substitute is granted, the "Proposed Document for Substitution" will replace the document that was unreadable or illegible. The clerk will certify the substituted document in accordance with Practice Book Section 7-8. The e-filing system will retain as viewable the originally-filed document for those who have access to the electronic file and a notice of the substitution will be provided to all appearing parties by means of a judicial notice. The originally-filed document is not available for reclaim or ruling.

2. Repair - Where a document originally scanned by court staff fails to reflect the original paper document, clerks may "repair" that document so that the scanned image accurately reflects the original paper document. When such a document is brought to the attention of the clerk, the clerk will obtain a court order allowing for the repair and then the clerk will repair the document. The e-filing system will retain the original document as viewable for those who have access to the electronic file, and notice of the repair will be provided to all appearing parties by means of a judicial notice. The original document is not available for reclaim or ruling.

3. Move Document - When a document originally scanned by court staff is misfiled in the wrong file, clerks can "move" the document. When the misfiling of a document by court staff is brought to the attention of the clerk, the clerk will obtain a court order allowing the moving of the document to the correct file. Upon receipt of the court order, the clerk will file the document in the correct file.

   In the original incorrect case, the misfiled document will remain viewable and a note will be displayed with the docket number of the correct case to which the document was moved and the entry number of the document in the correct case. The clerk will provide a notice of the move to all appearing parties in the original incorrect case and in the correct case by means of a judicial notice.

The following documents cannot be moved: Documents that are system-populated Judicial Branch forms, documents that are sealed, documents that are in the process of being repaired, and documents that have been substituted.

4. Conform Data Entry - When a filer electronically files case initiation documents with the court and the case type, return date, and/or name(s) of plaintiff(s) and/or defendant(s) entered into the system do not conform to the information contained in the summons served on the defendant(s) and submitted electronically to the court, the filer may seek the correction of specific data by means of a Request to Conform Case Initiation Data Entry Information to Summons (form JD-CL-096). The Request to Conform Case Initiation Data Entry Information to Summons must be filed by the attorney and served on all parties to the action in accordance with Sec. 10-13 et seq. of the Practice Book. Such request will be acted on by the clerk. Any objection to the request must be filed within ten (10) days of the filing of the request.

H. **Failure to comply with standards and procedures** – If any document is filed on paper instead of electronically as set forth in this section, the clerk shall not file the document and shall write "Not Accepted" across the file stamp on the document. The clerk shall return the document to the sender with a notice as to why it was not filed.

III. **Electronic filing (e-filing) Small Claims Actions -**

A. **Scope** –The following procedures are established by the Office of the Chief Court Administrator for the filing of documents in small claims actions by electronic means through the e-filing system under Section 4-4 and Section 24-3 of the Connecticut Practice Book. These procedures apply to all small claims actions that are established as e-filable by the Judicial Branch.

For information on electronic filing in civil matters, see Section II, above.

B. **Attorneys and Law Firms** – Unless an exclusion from electronic filing has been granted, attorneys and law firms are required to e-file the following documents in small claims actions:

1. Case initiation documents - Case initiation documents are the *Small Claims Writ and Notice of Suit*, JD-CV-40, Rev. 8-11, any related documents such as affidavits, and the *Statement of Service*, JD-CV-123, New 1-11. The filer will enter the information needed to create a small claims case record and scan the case initiation documents into an electronic image and file them electronically with the clerk.

2. Applications for Execution and related documents – Effective October 1, 2013, the following documents must be e-filed: Application for Wage Execution (JD CV 3); Application for Execution - Financial Institution – Debtor is not a natural person (JD CV 24N); Application for Execution Financial Institution – Debtor is a Natural Person (JD CV 24); Application for Execution - Property (JD CV 5); Execution Re-filed as Corrected – No Fee; Execution

Returned (partially satisfied, satisfied and/or unsatisfied) and Affidavit of Lost Execution.

C. **Self-represented Parties** - Self-represented parties enrolled in E-Services are permitted to e-file:

1. Case initiation documents - Case initiation documents are the *Small Claims Writ and Notice of Suit*, JD-CV-40, Rev. 8-11, any related documents such as affidavits, and the *Statement of Service*, JD-CV-123, New 1-11. The filer will enter the information needed to create a small claims case record and scan the case initiation documents into an electronic image and file them electronically with the clerk.

2. Applications for Execution and related documents – The following documents can be e-filed: Application for Wage Execution (JD CV 3); Application for Execution - Financial Institution – Debtor is not a natural person (JD CV 24N); Application for Execution Financial Institution – Debtor is a Natural Person (JD CV 24); Application for Execution - Property (JD CV 5); Execution Re-filed as Corrected – No Fee; Execution Returned (partially satisfied, satisfied and/or unsatisfied) and Affidavit of Lost Execution.

Note: It is the intent of the Judicial Branch to implement e-filing of all small claims case documents; however, currently, only case initiation documents and executions and related documents as listed in this subsection can be filed electronically. Other small claims case documents, including answers and appearances, must be mailed, faxed, or hand-delivered to the court.

D. **Signatures** - Documents submitted electronically through the e-filing system must be signed and fully executed in writing by the self-represented party as follows:

1. Case initiation documents and any other document requiring oath or affirmation must be fully executed with a pen-to-paper signature on the signature lines of the document before the documents are electronically filed with the small claims court through small claims e-filing. The placement on the signatures lines of the pen-to-paper signature shall constitute the signature of the self-represented party for the purposes of section 24-8 and section 24-9 of the Practice Book.

2. For all other documents electronically filed with the small claims court through small claims e-filing, entry in the small claims e-filing system of the User ID of the self-represented party who electronically filed the document will constitute the signature of the self-represented party.

E. **Filing Date/Confirmation of Filing** – An electronically transmitted document shall be deemed filed when it is received by the clerk's office during the normal hours of operation of the office. A document that is received outside of the normal business hours, including a day on which the clerk's office is closed, shall be deemed filed on the next business day the office is open. The time that a document is submitted and the time that the document is filed shall be recorded in the electronic filing database and shall be directly associated with the specific

document. Confirmation of the date and time of an electronic transaction and of the filing date of the document filed electronically shall be transmitted electronically to the filer. It is recommended that the filer of the document print out or electronically copy and retain the confirmation until the final resolution of the action.

F. **Document destruction and retention -** Documents filed electronically with the court will be printed out and retained in paper format as part of the small claims court file; documents filed with the clerk in paper format will be retained in that format as part of the small claims court file and any provision of these procedures to the contrary shall not be applied.

Note: It is the responsibility of each attorney or self-represented party who files a document electronically or in paper format to omit from the filing any confidential or otherwise privileged information unless the inclusion of such information is required by law, requested on a Judicial Branch form, or otherwise ordered by the Judicial Authority.

G. **Corrective Measures in Small Claims E-Filing** - In small claims cases, data entry may be conformed to the *Small Claims Writ and Notice of Suit*. The specific procedure is as follows.

When a filer electronically files case initiation documents with the court and the case type, venue, amount claimed, party type, and/or name(s) of plaintiff(s) and/or defendant(s) entered into the system do not conform to the information contained in the *Small Claims Writ and Notice of Suit* served on the defendant(s) and submitted electronically to the court, the filer may seek the correction of specific data by means of a *Request to Conform Case Initiation Data Entry Information to Small Claims Writ and Notice of Suit,* JD-CL-116, New 1-11. The *Request to Conform Case Initiation Data Entry Information to the Small Claims Writ and Notice of Suit* must be filed by the attorney or self-represented party and served on all parties to the action in accordance with Sections 10-12 through 10-17 of the Practice Book. Such request will be acted on by the clerk of Centralized Small Claims. Any objection to the request must be filed within ten (10) days of the filing of the request.

Currently, there is no capability to electronically substitute, repair or move e-filed documents in small claims matters. Amended documents may be filed by mail, fax or hand delivery with a motion describing the action sought.

H. **Failure to comply with standards and procedures** – If any document is filed on paper by an attorney or law firm without an exclusion from E-Services requirements instead of electronically as set forth in this section, the clerk shall not file the document and shall write "Not Accepted" across the file stamp on the document. The clerk shall return the document to the sender with a notice as to why it was not filed.

IV. Facsimile Filing of Motions, Pleadings, or Other Documents

A. **Scope** - Pursuant to Section 4-4 of the Connecticut Practice Book, the following procedures are established by the Office of the Chief Court Administrator for the filing of motions, pleadings, or documents by electronic means through facsimile filing. Attorneys and law firms without an exclusion from electronic services requirements cannot file documents through facsimile filing in cases in which they have an appearance on behalf of a party if electronic filing through e-filing is mandatory for the case.

B. **Form/Page limits** - Any pleading, document, or other paper filed by facsimile transmission shall be accompanied by a Facsimile Transmission Cover Sheet (JD-CL-73) prescribed by the Office of the Chief Court Administrator. Such filings may not exceed twenty pages, including the cover sheet, unless otherwise directed by the court.

C. **Original Document/Certification** – The facsimile transmission received by the clerk shall be deemed the original. A facsimile transmission of a signed pleading, document, or other paper shall be considered signed for purposes of Section 4-2 and Section 10-14 of the Practice Book. The attorney or party shall retain the signed copy of the pleading, document, or other paper during the pendency of the action, any appeal period, and any applicable appellate process. The signed copy retained by the filer shall contain a certification signed by the filer indicating that the document is a true copy of the document that was transmitted by facsimile to the clerk. The filer shall produce the signed copy upon request of the Court. If the filer fails to produce the document, the Court may take any action and impose any sanction it deems appropriate.

D. **Specific Types of Documents** – Except as otherwise provided in these procedures, any pleading, document, or other paper may be filed with the court by facsimile transmission.

1. Documents requiring oath/affirmation - Documents that require an oath or affirmation may, if signed and fully executed in writing, be submitted by facsimile. The filing party shall retain the original paper documents throughout the pendency of the action, any appeal period, and any applicable appellate process.

2. The following may **not** be filed by facsimile:

   a. Any pleading, document, or other paper that commences an action,
   b. Any filings that must be accompanied by any fee or other payment,
   c. Criminal summonses and complaints,
   d. Uniform Arrest Reports, arrest reports, bond forms and seized property inventories, and
   e. Requests, applications, petitions, and other documents pertaining to restraining orders
   f. Documents in cases for which electronic filing through e-filing is mandatory unless the attorney or law firm has been granted an exclusion from electronic services requirements.

E. **Filing date/Confirmation** – Facsimile filings shall be complete upon the receipt of the entire document by the clerk's office. Facsimile transmissions received by

the clerk's office during the normal hours of operation of the office shall be deemed filed that day. A document that is received outside of the normal business hours, including a day on which the clerk's office is closed, shall be deemed filed on the next business day upon which such office is open. The date of filing shall be as recorded on the document by the clerk. The filer must cause the transmitting facsimile machine to print a transmission record which shall be retained by such filer for each transmission. If the facsimile document is not filed with the court as set forth herein because of an error in transmission unknown to the sender or because of a failure to process the facsimile document when received by the court, the filer may move for an order to allow the filing of the document as deemed appropriate by the court. This motion shall be accompanied by the transmission record, a copy of the document transmitted, and an affidavit of transmission.

F. **Failure to comply with standards and procedures** – If a document exceeds the page limit, is incomplete as transmitted, is faxed to the incorrect court, or is otherwise not in compliance with the requirements of this section, the clerk shall not file the transmitted document but shall destroy it and return the cover sheet to or otherwise notify the sender as to why the document was not filed.

V. **Online short calendar markings**

A. **Scope** – Short calendar markings are governed by the Civil or Family Short Calendar Standing Orders. Those standing orders govern the time within which markings must be made, the method by which those markings must be made, and the information that must be provided by the person marking the matters. They are posted on-line at the following link: http://www.jud.ct.gov/external/super/StandOrders/default.htm.

B. **Marking Methods** – Electronic short calendar marking through E-Services is mandatory for all attorneys and law firms, unless an exclusion from electronic marking has been granted. Only self-represented parties, and attorneys or law firms with an exclusion, may mark their cases by telephone. Self-represented Parties approved for electronic access to their civil case can mark short calendar matters electronically through E-Services.

Note: Markings by facsimile are not accepted.

C. **Obtaining an Exclusion** – Attorneys and law firms can apply for an exclusion from electronic services requirements by completing the Request for Exclusion from Electronic Services Requirements form (JD-CL-92). The form shall be submitted to E-Services Exclusion Requests, Superior Court Operations, 90 Washington Street, 3rd Floor, Hartford, CT 06106 for processing. Each exclusion request shall be ruled on by the Chief Court Administrator or the Chief Court Administrator's designee.

D. **Markings Available** – Regardless of the manner of transmittal, the following designations may be used in marking matters on the short calendar. Information on marking matters on specific calendars is found in the calendar notices.

1. "Ready" – This marking is used for civil and family arguable matters:

a. to have a matter that is listed on the calendar as ARG (arguable) heard by the court on the scheduled date.

b. to ask the court to rule on a non-arguable family discovery or deposition motion without a hearing. You do not come to court on the date of the calendar when you mark a non-arguable family discovery or deposition motion "Ready."

c. to have the following matters listed as non-arguable (N/A) on the property calendar (currently Calendar 02) heard by the court on the scheduled date:

- Motion to open and modify judgment;
- Motion to open and vacate judgment;
- Motion to open judgment;
- Motion to open judgment and extend the law day; and
- Motion to open judgment and extend the sale date.

2. Take Papers" – This marking is used for civil arguable and non-arguable matters:

a. To ask the court to decide a civil arguable matter by reviewing the papers. Civil arguable matters marked "Take Papers" may be handled in one of two ways: (1) the court may decide the matter by reviewing the papers, or (2) the court may have a hearing.

b. To ask the court to review and decide a civil non-arguable matter on the papers.

c. To ask the court to hear argument on a civil non-arguable matter. If you want to ask the court for a hearing on a motion listed as N/A, you must mark the motion "Take Papers" and file a Request for Argument. Do not come to the courthouse on the date of the calendar unless you have received a specific notice from the clerk directing you to do so.

Note: Do not use a "Take Papers" marking to mark a civil matter that appears on a calendar if a request for argument has been granted on a non-arguable motion or the Court has granted or required argument on any other matter.

3. "Off" –This marking may be used for civil (arguable or non-arguable) or family matters:

a. To inform the court that no action is required.

Note: If a motion is not marked, the court will take no action on it.

b. To change a "Ready" or "Take Papers" marking that has already been made to inform the court that no action is required.

E. **Notification/Confirmation** – On arguable matters, counsel and self-represented parties must bring the confirmation of the marking to the short calendar hearing. This confirmation may be in the form of a *Short Calendar Markings Confirmation and Receipt* produced upon completion of the online electronic Short Calendar Markings Entry transaction or a detailed signed statement from the person who telephoned the marking to the court containing the name of the person who marked the case, telephone number, and the date and time of the marking.

VI. **Electronic Citations (eCitations) -** The **Procedures and Technical Standards for the State of Connecticut Centralized Infractions Bureau Electronic Citations Processing System (eCitations)** can be accessed here.

These revised E-Services Procedures and Technical Standards are approved as amended and are effective September 20, 2013.

The Honorable Barbara M. Quinn
Chief Court Administrator

INSTRUCTIONS FOR SHORT CALENDAR MARKINGS

1. Print the list weekly from the Judicial Website. Find out on Citylaw what attorney is handling each of these matters

2. In the "K" drive, find Npepe's directory. You will see all the calendars listed (ex. Calendar 4 - New Haven). These are memos for each calendar. Click on the Calendar/memo you need.

3. Prepare a new memo to all attorneys who have cases on the calendars. Distribute the memo and a copy of the calendar to the appropriate attorney.

4. **KEEP THE ORIGNAL MEMOS AND THE ORIGINAL CALENDARS FOR NANCY PEPE**

5. Once the attorneys tell you to mark a matter ready, you need to mark it ready on **E-Services** (**Go to the Judicial Website. At the bottom of the screen hit E-Services – Sign In: Juris No. 042715 – Password: 165 Church**.) **Non arguable matters (Calendar 4) are marked "T" for Take Papers. Arguable matters (Calendar 1) are marked "RA" for request argument. THE COURT WILL NOT ACCEPT FAXED MARKINGS**

6. Print out 2 copies of the receipt of the marking. Give one to the attorney. **Fax** the other copy to all opposing counsel(s) that need to be notified of the marking. (Give a copy of the faxed confirmation sheet to the attorney and keep a copy of the marking receipt from E-services and a copy of the faxed confirmation sheet for Nancy Pepe)

7. **You must make all markings by 4:00 p.m. on Thursday.**

8. If you have a Meriden Calendar, you need to call the marking line Friday after 10:00 a.m. to hearing the type to confirm that the case will be heard **For Meriden, the court will decide if argument is needed no matter how you mark it. If you don't hear the position number on the type when you call on Friday, that means no argument is required and the matter will be taken on the papers.**

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SEARCH

Civil Matters - Statewide Standing Orders

Standing Orders
Superior Court
Superior Court Judges

Civil Short Calendar Standing Order

1) All attorneys and law firms are required to mark their Short Calendar matters electronically through E-Services unless excluded from this requirement as set forth in paragraph 3 below. Telephone markings are not available to attorneys unless an exclusion from E-Services has been obtained.

Note: The following items are exempt from the marking requirements, and will be heard on the day they appear on the short calendar: Motions/Applications for exemption; motions for modification of executions and examination of judgment debtors and all motions for judgment on report of an attorney trial referee or factfinder, and any objections about the motions.

2) Self-represented parties who are enrolled in E-Services may mark their Short Calendar matters electronically through E-Services but are not required to do so. Self-represented parties may continue to mark Short Calendar matters by telephone. See more Information about enrollment in E-Services and electronic access to civil cases.

3) Attorneys who require an exclusion from E-Services requirements under the ADA may apply for an exclusion by submitting the Exclusion from E-Services Requirements form (JD-CL-92) in accordance with the instructions on the form. The form is available online or at any judicial district clerk's office or Court Service Center.

4) Civil Short Calendar in each judicial district will start at 9:30 a.m. on Monday of each week, unless it is rescheduled.

5) The ordinary marking period is from 9:00 a.m. Tuesday to 4:00 p.m. Thursday of the week before the Short Calendar. If a state holiday falls on the Thursday before the calendar, matters may be marked from 9:00 a.m. Tuesday to 5:00 p.m. Wednesday. If a state holiday falls on the Friday before the calendar, matters may be marked from 9:00 a.m. Tuesday to 11:00 a.m. Thursday. If a calendar is canceled due to unexpected events, parties may reclaim their motions to the next available calendar. If however, the matter needs immediate action by the court, the party may apply for permission to schedule an earlier hearing date with the court. **Note:** all citations must be re-issued unless the court orders otherwise. Markings must be submitted electronically through E-Services. Attorneys who have obtained an exclusion from E-Services requirements and self- represented parties not enrolled in E-Services must submit markings by calling the telephone marking line. Self-represented parties enrolled in E-Services may mark their matters electronically or by calling the telephone marking line.

6) The following information is required when making a telephone marking:

- The position of the case on the calendar
- The name and docket number of the case
- The entry number and title of the motion
- The full name of the person making the marking and the law firm name, if applicable
- Confirmation that counsel and self-represented parties of record have been notified of the marking

7) Please do not call the clerk's office to confirm delivery. The Short Calendar Markings Confirmation and Receipt produced upon completion of the electronic Short Calendar Markings Entry transaction is the confirmation that the marking has been received.

See: Chief Court Administrator's Notice Regarding Arguable Civil Short Calendar Matters

The Honorable Linda K. Lager
Chief Administrative Judge
Civil Division

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Instructions on Marking Short Calendar Matters Electronically

1. Tell the attorneys and other self-represented parties in the case by telephone, fax or, if the other attorneys or self-represented parties have agreed in writing, by email how you are marking your motion or pleading.
2. Log in to E-Services from the Branch website at: www.jud.ct.gov.
3. Select **Civil/Family Menu** from the E-Services menu.
4. Select **Short Calendar Markings Entry** from the **Civil/Family Menu** page.
5. Select the **Location** and **Court Type** for the calendars.
6. Select **Sort Results** to display cases by case name, docket number, location, entry number, calendar sequence number or motion.
7. Choose **Search.**

> **Note:** Motions or objections display separately. If a case has more than one motion or objection, the name or the case and the docket number will appear once for each motion or objection.

8. Each motion/objection must be marked separately. For civil matters, select **"R" (Ready)**, **"TP" (Take Papers)** or **"O" (Off)**; for family matters, select **"R" (Ready)** or **"O" (Off)**.

   More information about the markings options can be found in the Procedures and Technical Standards for E-Services and the Short Calendar and the Marking Process quick card.

> **Note:** Do not use a "Take Papers" marking to mark a matter that appears on a calendar if a request for argument has been granted on a non-arguable motion, or if the Court has granted or required argument on any other matter.

9. Check the box next to the certification.
10. Enter the name and telephone number of the individual submitting the markings
11. Click **Enter Markings** and print the Short Calendar Markings Confirmation and Receipt.
12. Be sure you have given notice of the markings to all other attorneys and self-represented parties of record.

> **Note:** To change a marking you have entered, you can log in to E-Services at any time during the marking period, go to the **Civil/Family Menu**, choose **Markings Entry**, and change the marking. Each time you go to **Markings Entry**, you will see the markings next to all motions or objections defaults to "No Change."

For questions about marking the short calendar, contact eservices@jud.ct.gov or call (866) 765-4452.

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SUPERIOR COURT CALENDAR NOTICES

See specific Calendar Notice for hearing location.

*** Standing Orders ***

Civil/Family Short Calendar Procedures

*** Web Forms ***

Official Court Webforms

AAN - Ansonia-Milford at Milford
DBD - Danbury at Danbury
FBT - Fairfield at Bridgeport
FST - Stamford-Norwalk at Stamford
HHB - New Britain at New Britain
HHD - Hartford at Hartford
KNL - New London at New London
KNO - New London at Norwich
LLI - Litchfield at Litchfield
MMX - Middlesex at Middletown
NNH - New Haven at New Haven
NNI - New Haven at Meriden
TSR - GA19 at Rockville
TTD - Tolland at Rockville
UWY - Waterbury at Waterbury
WWM - Windham at Putnam

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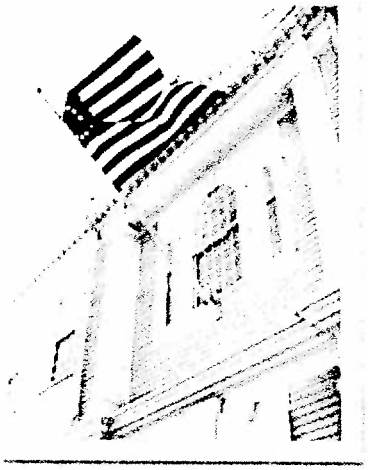
State of Connecticut
Judicial Branch

Case L

Short Calendars



You can view short calendars and family support magistrate calendars:

1. for a specific judicial district, by selecti **Court Location**
2. for a specific attorney or law firm by se **By Juris Number**
3. for Motions to Seal or Close by selecti **Motions to Seal or Close**.

Short calendars are generally made avai on Thursday afternoon at least a week in advance of the calendar.

To view the calendar notices only, select **Calendar Notices**.

Select **Court Events by Date** or **Court E by Juris Number** to see case informatio court events, including pretrials, trial management conferences or trials, displa date of the event or by juris number.

Case information is updated as the inforr is entered into the case management sys although information on scheduled event updated nightly.

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ISOClaimSearch®

Medicare Secondary Payer Reporting Service

User Guide

Version 3.6

February 2012

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INTRODUCTION

ISO has developed the ISO ClaimSearch® Medicare Secondary Payer Reporting Service to help insurers comply with mandatory claim reporting requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173). The legislation requires reporting of bodily injury claims filed by Medicare-eligible claimants to the U.S. Department of Health and Human Services Center for Medicare & Medicaid Services (CMS). Failure to report carries a $1,000.00 per diem, per beneficiary civil penalty.

ISO ClaimSearch, in coordination with insurers and the insurance trade associations, worked with CMS to design a comprehensive Medicare Secondary Payer Reporting Service. The service will report Medicare-eligible claimants to CMS on behalf of ISO ClaimSearch participating companies in conformance with the legislation. By reporting through ISO ClaimSearch, companies will realize significant savings and workflow process efficiencies.

About This User Guide

This user guide has been created as a resource for customers who have chosen ISO as their reporting agent for Medicare Section 111 reporting. It will guide the implementation of changes to existing processes. It is not practical for this user guide to encompass all information for reporting since much of the Medicare Section 111 reporting is based on existing ISO ClaimSearch processes. We have included as much information in this manual as we felt was practical and have provided a section in this manual listing other AVAILABLE RESOURCES.

This manual has been created based on requirements provided in the CMS MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Worker's Compensation User Guide Version 3.3 published on December 16, 2011 as well as recent alerts posted by CMS. ***Information published in this guide may be updated subject to future CMS changes.***

This user guide is not meant to replace the CMS MMSEA Section 111 User Guide. Companies must be familiar with the CMS reporting requirements and regulations.

The information contained in this publication was obtained from sources believed to be reliable. ISO Services, Inc., its companies and employees make no guarantee of results and assume no liability in connection with your use of the information or the timeliness, accuracy or completeness of the information herein contained.

Summary of Changes

In this version of the ISO ClaimSearch Medicare Secondary Payer Reporting Service User Guide 3.6, the following changes have been made since version 3.5.

- Page 24 – A statement was added for system-to-system companies to indicate which ICD9 codes are sent to CMS if they are reported on both the UC01 and UEX3 records.
- Page 31 – Two new warnings were added. Warning 71 – No fault limit exceeds $99,999,999.99; Warning 72 – Total of TPOC amounts exceed $99,999,999.99.
- Page 32 – SSN is no longer handled as a key field change per CMS' new requirements.
- Page 36 – a new grid was added to outline the new dates and threshold amounts for liability TPOC reporting.
- Page 39 – a statement was added to indicate that the claimant name must match (in addition to other key fields) on claims which are converted from legacy to Universal Format.
- Page 45 – additional error codes SP32, SP50, TN99 were added. Compliance codes 02, 04-09 were marked as obsolete as of October 2011.
- Pages 45-46 – TIN Reference Response File section was added to explain the process for the new TIN response files posted by CMS as of October 2011.
- Page 49 – the screen-shot for the Quarterly Report Statistics has been replaced. The stats for files sent and files received now appear on separate screens with a drop-down to choose files sent or files received from CMS.
- Page 118 – additional error codes SP47, SP50 and TN99 were added.
- The filler in the query response, acknowledgement and error file header and trailer records have been updated to equal 600 bytes.
- The Reported Source on the query response file has been updated to include additional sources. Additional legacy sources include A – ACE software, D – paper (data entry), I – IIN, O – Online, T – tape, X – tracs, 3 – 3780.

The following changes have been made since version 3.5

- A new lawyer service provider role (page 20) has been added to be used specifically for reporting a lawyer representative to CMS.

  Currently, ISO allows reporting of multiple lawyer service providers on one claim. CMS accepts only one lawyer representative in reports. If more than one lawyer is entered in the claim report, ISO chooses the first lawyer record found on the system that contains all of the data fields required by CMS (name, address and phone number) and uses that lawyer record in the quarterly claim file for CMS. Using this method to choose the lawyer to report when more than one is entered can result in sending to CMS a lawyer who may not be handling the claim or may not be the primary representative.

In order to control exactly which lawyer is sent to CMS, ISO ClaimSearch has added a new "LS" (Lawyer for CMS Claimant) role to be used for either claimants or additional claimants. When this role is used in a report, it will indicate the lawyer to be reported to CMS, even when there are other lawyers included on the claim. If any of the CMS-required data fields are missing for this role, you will receive a warning message on your ISO ClaimSearch match report indicating the missing fields. If you do not add the missing fields, the claim will be rejected when sent to CMS.

You must use the LS role if you report multiple lawyers and want to control which one is sent to CMS. If you do not use the new LS role, ISO ClaimSearch will continue to send the first lawyer found on the system with all of the required fields. If you use the LS role for multiple lawyers on one claim, the first one reported will be sent to CMS.

- Additional warnings have been added at the request of our participants to address some of the more common reasons for CMS rejections. See page 30.

  New warnings include:

  45 – 48 TPOC dates 2- 5 must be greater than the CMS Date of Incident

  49 Total of all TPOC amounts is below the dollar threshold

  50 – 68 ICD9 codes 1 – 19 are invalid

  69 TPOC coverage has ORM indicator = Y. Change to N. If needed add ORM coverage/loss with ORM = Y.

  70 ORM claim was entered with ORM = N. Claim will not be sent to CMS until ORM = Y or until TPOC date is entered.

  Other warning changes include:

  Warning 22 & 43 have been removed.

  Warning 21 is re-worded and will only be generated if the ICD9 Diagnosis Code is Missing (new warnings will alert you if the ICD9 is invalid).

  Warning 44 is re-worded to indicate that the TPOC Date 1 must be greater than the CMS Date of Incident (new warnings were created for TPOC Dates 2 – 5).

- HICN is no longer considered a key field change. Description of Illness or Injury is no longer considered an update field (page 33).

- Page 32 was updated to explain new reasons for delete transactions: For claims already accepted by CMS, if you report the "Do not send to CMS" indicator at either the claimant or coverage level, if you remove the Medicare eligible indicator, if you change the coverage to a non-CMS reportable type, or if the claim is voided from the ISO ClaimSearch database, ISO will send a "delete" record (Action Type "1") to CMS.

- The reference to the ORM termination date needing to be more than 30 days greater than the date of incident has been removed due to a change in CMS requirements (page 35).

- ISO now will alert you via a warning message if your TPOC claim is below the dollar threshold (page 36).

- Additional information has been provided as to the reason for many claims receiving Disposition 49.

- Additional compliance codes have been added (page 45). ***Compliance Codes 04 through 09***

  These compliance codes are sent when invalid TIN/Office Code Addresses are sent on the TIN Reference Field Detail Record. Codes are provided for invalid Mailing Address Line 1 (Code 04), invalid Mailing Address Line 2 (Code 05), Invalid City (Code 06), Invalid State (Code 07), Invalid Zip Code (08) and Invalid Foreign Address (Code 09). See the CMS ALERT: TIN Reference File Address Validation Information dated November 18, 2010 for more information.

- The Resources section has been updated.

- At the request of customers who need additional information on the result files to match claims back to their system, additional fields have been added to the Query Response, and Claim Acknowledgment and Error files. The following fields were added to the Query Response file: ISO File Number, Policy Number, Date of Loss, Adjuster Name (if more than one adjuster appears on the claim, the first adjuster will be provided), Insured Name, Submitted Claimant Last Name, Submitted Claimant First Name, Claimant Middle Name, Routing/Miscellaneous Info, Claim Source (legacy or Universal Format), and Reported Source (FTP, XML, MQ or Web). If using the text file, the size of the file is now 600 bytes, so you may need to adjust your programming to account for the larger response file. See Appendix C. The following fields were added to the Acknowledgement and Rejection files: ISO File Number, Policy Number, Date of Loss, Adjuster Name (if more than one adjuster appears on the claim, the first adjuster will be provided), Insured Name, and Routing/Miscellaneous Info. If using the text file, the size of the file is now 600 bytes, so you may need to adjust your programming to account for the larger response files. See Appendix D & E.

- Page 159 – a note was added to alert you to the potential problems of choosing default or generic ICD9 codes.

SERVICE OVERVIEW

The ISO ClaimSearch Medicare Secondary Payer Reporting Service will help insurers comply with mandatory claim reporting requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. The legislation, effective July 1, 2009, could affect every bodily injury settlement that involves an insurance carrier or self insurer and a Medicare-eligible claimant/plaintiff.

Section 111 of the act adds new mandatory reporting requirements for all responsible reporting entities (RRE), group health plan arrangements, property casualty and workers' compensation insurers, and self-insureds. The legislation requires reporting of bodily injury claims filed by Medicare-eligible claimants to the U.S. Department of Health and Human Services Center for Medicare & Medicaid Services (CMS).

CMS has added more than 100 distinct fields of data that you must report. Reporting will occur as follows:

- Quarterly, ongoing – all no-fault insurance and non-contested workers' compensation claims
- Single instance – all contested cases resulting in "a single settlement, judgment, award or other payment"

The service includes a Medicare-eligibility query function, data collection and screening, automated claim file submissions, and processes for handling CMS acknowledgement and rejection notices.

The ClaimSearch Medicare Secondary Payer Reporting Service solution is integrated with the existing ISO ClaimSearch claim-reporting process. To participate, your company must use the ISO ClaimSearch Universal Format reporting specifications and report additional data elements to ISO ClaimSearch. The addition of the new elements required by CMS should require only minimal programming changes for customers using system-to-system communications.

ISO ClaimSearch offers a web reporting option for companies that are unable to capture the additional fields in their systems or who do not have the necessary programming resources. Companies will be able to update previously reported claims with the additional CMS-required information through the ISO ClaimSearch web interface.

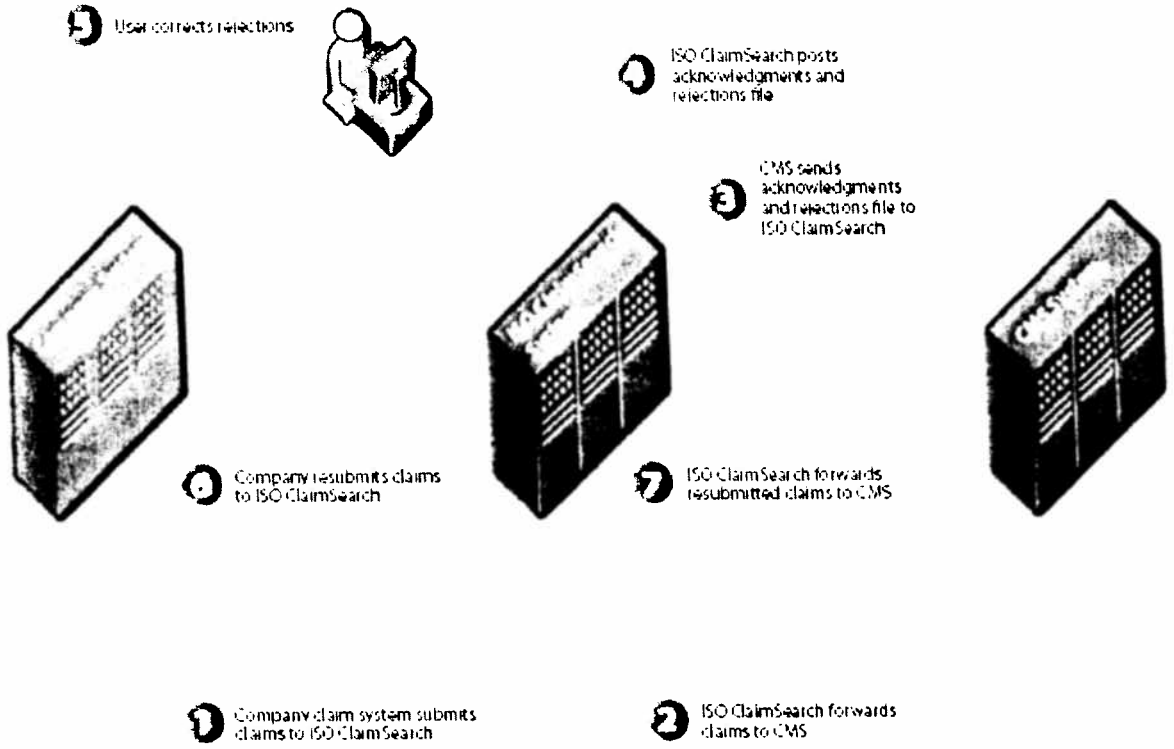
The ISO ClaimSearch Medicare Secondary Payer Reporting Service offers:

- Timely quarterly reporting to CMS
- Help in identifying Medicare-eligible individuals through a monthly query function
- A process for notifying customers of the claims CMS rejects
- A process for correcting CMS rejections
- Timely warnings when claims with Medicare-eligible claimants are missing CMS-required fields
- An optional pre-query extract process to identify claims already reported to ISO ClaimSearch and assist in the monthly query process
- Management reports to assist with compliance

Choosing ISO as your CMS reporting agent helps you to:

- save internal programming costs
- streamline workflow (as you are already reporting this data to ISO ClaimSearch)
- comply with the CMS regulations
- obtain Social Security numbers (SSN) and other public-records information you may need through our optional Append-DS service

The ISO ClaimSearch Medicare Secondary Reporting Service Workflow



TIMELINES

Registration with CMS (May 1, 2009 - On-Going)

Companies must register their data-reporting method with CMS for each responsible reporting entity (RRE). CMS will assign a quarterly reporting period to each RRE at registration. Registration remains open past this date if a new company needs to register a new responsible reporting entity (RRE) or an existing RRE, to request more RRE codes.

Registration with ISO (Current/On-Going)

In addition to registering with CMS, ISO ClaimSearch participants choosing to use ISO as the reporting agent must sign an ISO Product Supplement and complete Authorization Forms.

Query Process (In Production)

ISO is submitting production query files to CMS on behalf of customers who have completed the ISO registration mentioned above and have requested the optional query service. Customers may use the results of the production queries to begin updating claims. If your RRE has not yet had a query performed and you are unsure why, please contact us at claimsearchmsp@iso.com.

Pre-Query Extract (Current/On-Going)

For a nominal fee, Companies may request from ISO a pre-query extract of claims currently in the ISO ClaimSearch database to determine which additional claims must be reported, which claims must be converted to Universal Format, or which claims must be updated with additional data elements.

Testing Universal Format Changes with ISO (Current/On-Going)

Companies that report via a system-to-system interface and have completed the Registration with ISO mentioned above may test any programming changes to their Universal Format interface through their designated ISO Testing Representative. Once testing is complete, customers may begin entering the information in the production environment. Companies reporting via the web do not need to test; the new fields are available in production now.

Testing Files with CMS (Complete)

ISO completed "pilot testing" with the Coordination of Benefits Contractor (COBC). By completing the pilot, the COBC will automatically move the RREs from Testing Status to Production Status. If the status of your RRE still shows as "Testing", please contact your EDI representative and ask to be switched to "Production" status. There is no further testing an RRE is required to perform in order to be in Production Status.

Production (Current/On-Going)

Companies are required by CMS to submit production files based on the pre-determined quarterly reporting schedule. As of 1/1/11, ISO is now sending production quarterly claim files to CMS based on each RRE's assigned reporting period.

REGISTRATION OVERVIEW

Registration for reporting of injury claims to the Department of Health and Human Services Center for Medicare and Medicaid Services (CMS), in compliance with the mandatory claim reporting requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173), began on May 1, 2009 and will remain open for companies that are new or that must register a new RRE. Prior to registration, companies planning to use ISO ClaimSearch to report their Medicare-eligible claimants will need to be familiar with the registration process.

We appreciate your consideration of ISO ClaimSearch as your reporting agency for CMS reporting. You can send all applicable claims to ISO ClaimSearch for reporting to CMS, if you report using the ISO ClaimSearch Universal Format by system-to-system reporting or via the ISO ClaimSearch website. The instructions below will help you register with CMS if you plan to use ISO ClaimSearch as your reporting agency.

Registering With CMS

The registration for CMS reporting is accessible via the Coordination of Benefits website at www.Section111.cms.hhs.gov. The registration process involves five steps:

- Identify an Account Representative, Account Manager and Account Designees
- Determine reporting structure
- Register the new Responsible Reporting Entity (RRE) on the CMS website
- RRE account set up on the CMS website
- Return signed Profile report

The CMS Registration for Medicare Secondary Payer, Section 111 Reporting requires the information specified for each RRE. Required information is:

- Name and address of the entity (insurer or self insurer)
- Tax ID number
- NAIC code (if an insurer)
- Optional subsidiary information

STEP 1 - Identification of an Authorized Representative

This is a senior manager who is authorized to enter into an agreement (must sign Profile Report and Data Use Agreement).

- Authorized Representative will designate an Account Manager.
- The Authorized Representative will receive e-mail correspondence and compliance information from CMS.
- The Authorized Representative will receive the PIN and RRE ID which is to be used to register to report to CMS.
- The Authorized Representative must annually confirm that the current profile report is correct.

- **Identification of the Account Manager (one per RRE)**
  - Registers on the Coordination of Benefits Contractor Website (COBSW) to obtain a Login ID and password.
  - Responds to questions on the registration form.
  - Can appoint other entities as Account Designees.
    NOTE: The most appropriate status for ISO ClaimSearch under the company (RRE) is as an Account Designee; ISO should not be chosen as the Account Manager.

- **Identifying the Agent and Account Designees (ISO ClaimSearch)**
  - The Account Manager will provide Agent information to CMS as part of the registration process (*indicating ISO ClaimSearch as an Agent for CMS reporting*).

Agents can be designated as Account Designees.

This is the preferred status for ISO ClaimSearch.

As an Account Designee, ISO ClaimSearch will be able to upload and download company files to and from CMS. Account Designees are also authorized to review file processing status and statistics. ***NOTE:*** *Some RREs who have already registered ISO as the agent did not choose the five ISO representatives as Account Designees. This is an important step because ISO will not be able to transmit files without this designee status. If you have already registered, please make sure you chose the five ISO representatives as Account Designees.*

Once the online registration is completed, CMS will send a profile report that includes the RRE ID, your production Live Date, and the ongoing quarterly reporting period.

STEP 2 - Determine Reporting Structure

Only one file per RRE can be reported during the assigned quarterly reporting period. If there is a need to report more than one file per RRE per quarter, CMS recommends that a second RRE code be obtained.

STEP 3 - New RRE Registration

In this step, a company representative (does not need to be the Account Representative) will select New Registration on the CMS website and enter the registration information above. CMS will validate the information, and will send notification *to the Authorized Representative* with a PIN and RRE code. The Authorized Representative will give the codes to the Account Manager, who will complete the registration via the CMS website.

STEP 4 - RRE Account Set Up on the COBSW (CMS) website

The Account Manager must complete this online.

- Use the PIN and RRE ID sent by CMS to the Account Representative
- Access the Account Setup button on the COBSW (CMS) website at www.Section111.cms.hhs.gov.

It is during this process that the information on ISO ClaimSearch as a reporting agent is entered.

Important: *You will need the following information to register ISO as your Agent.*

- Name: ISO Services, Inc.
- Address: 545 Washington Blvd. Jersey City, NJ 07310
- Contact e-mail: Claimsearchmsp@iso.com
- TIN: 133973142
  ***When entering the TIN, please do not include dashes or spaces.

Each RRE must select a file transmission method. If ISO is your agent, indicate the transmission method of SFTP.

After the Account Manager successfully receives a COBSW (CMS) Login ID, he/ she can invite an Account Designee to register for Login IDs. Only one Login ID is allowed per user.

- When adding a Designee, the name and email address of the Account Designee must be an individual; company names are not allowed.

Please enter *all four* ISO ClaimSearch contacts below as Account Designees:

- John A. Giknis: jgiknis@iso.com
- Lynn M. Roberts: lmroberts@iso.com
- Bryan Berkowitz: bberkowitz@iso.com
- Marilyn Orthouse: morthouse@iso.com

In addition to the four designees above, please include ***one*** additional designee based on the reporting group to which you were assigned. For example, if you were assigned to Group 5, choose the four designees listed above plus the additional one for mspreporting5@iso.com.

NOTE: CMS has automatically added the appropriate designee below to many existing accounts, but if they did not add it to your RRE's account, please do so. Adding the additional designee will assist ISO in transmitting files and investigating issues.

Group 1 -	mspreporting1@iso.com	Group 7 -	mspreporting7@iso.com
Group 2 -	mspreporting2@iso.com	Group 8 -	mspreporting8@iso.com
Group 3 -	mspreporting3@iso.com	Group 9 -	mspreporting9@iso.com
Group 4 -	mspreporting4@iso.com	Group 10 -	mspreporting10@iso.com
Group 5 -	mspreporting5@iso.com	Group 11 -	mspreporting11@iso.com
Group 6 -	mspreporting6@iso.com	Group 12 -	mspreporting12@iso.com

The Authorized Representative will receive a profile report via email from CMS, once the account set up has been completed on the COBSW. It will include:

- Registration summary information
- Data file transmission information (This will include ISO transmission information, as agent)
- The RRE ID for all reports
- The assigned production live date and ongoing quarterly submission timeframes
- Contact EDI representative

STEP 5 - The Authorized representative is to sign the Profile report and return it to the Coordination of Benefits contractor.

*****NOTE: Your RRE will remain in Set-Up status until the profile report is returned at which time your status will be changed to Testing or Production status.**

Deciding How Many RREs Your Company Needs

An RRE is required for the submitting of claims to CMS and the receiving of acknowledgements and rejections from CMS. Acknowledgements and rejections are posted in the Account Management section of the ISO ClaimSearch web site. Each RRE will require a separate registration with CMS and will receive a unique RRE Code, Reporting Period and EDI Representative.

Companies may register one or more responsible reporting entities (RREs). If a company can report to ISO ClaimSearch in one transmission, we recommend that the company establish one RRE at the group or company level to keep reporting simplified. The more RREs that a company chooses, the more complex the reporting process will be. However, companies may consider using separate RRE codes if:

- The company reports claims to ISO ClaimSearch under a separate reporting code
- The company needs ISO to separate data submitted to CMS
  - By line of business or business unit
  - By geographic region (for example, Northeast, Midwest, West)
  - For organizational requirements (for example, if a company wants separate reporting for a group or office level)
- The company uses third-party administrators and is required to segregate results
- Some of the claims involve self-insurance, requiring separate registration by the self insured

We recommend that companies be familiar with their ISO ClaimSearch participant profile and how the company is currently reporting to ISO ClaimSearch. Most companies report as a group, using one ISO ClaimSearch company code. Some groups have sub-groups, companies or business units that report separately to ISO ClaimSearch. For further clarification, check your company's Integrated Statistics Report in the Account Management section of the ISO ClaimSearch website for more details on how your company reports.

Other, generally smaller, single-company configurations report to ISO ClaimSearch on an individual company basis.

RRE Identification When Reporting Claims, Using the CMS Query Function and Reporting To CMS

For insurers or self-insured companies, if your company has more than one RRE which ISO cannot link to a specific company or office, you will need to identify the RRE code on each bodily injury claim reported to ISO ClaimSearch that will be queried or submitted to CMS. If your company only has one RRE code, TIN and Site ID for the company or an office, no further steps will be needed – identification of your RRE code will be automatic, as you will have been set up under that RRE code in ISO's membership system. Since TPA's report for multiple insurers or self-insureds, TPAs will always have to supply the RRE code on each claim to be queried or reported to CMS.

When using the CMS Query function you will also need to identify the RRE code for the query file to indicate to us which claimant is assigned to which RRE. A separate query file will need to be submitted for each RRE. If your company has only one RRE, the identification will be automatic.

The CMS registration process is flexible regarding the number of responsible reporting entity (RRE) codes a company can select. Companies can report in nearly all reporting configurations. It is important to note, however, that **each** RRE must complete the registration process individually. We will be happy to work with participating companies to review their reporting procedure.

Signing Up With ISO

Companies that wish to report to CMS through ISO ClaimSearch must contract and authorize ISO ClaimSearch to be their reporting agent. A Product Supplement and Authorization Form are required by ISO ClaimSearch in order for ISO ClaimSearch to submit data on the company's (RRE's) behalf. If the company has multiple RREs, only one Product Supplement is required; however, an Authorization Form must be completed for each RRE. The Authorization Form is where you will provide ISO with your RRE code(s), TIN(s), SITE ID(s), Reporting Period, Account Manager and other information necessary for reporting. See Appendix E for a sample Authorization Form and Instructions. Product Supplements and Authorization Forms can be obtained through claimsearch.sales@iso.com.

NOTE: *Completing this process with ISO is important. ISO will not be able to query your company's claims or report your company's claims to CMS until ISO ClaimSearch CMS registration is complete, even if you have already registered with CMS.*

For system-to-system companies who wish to test Universal Format programming changes for fields such as the Medicare-Eligible Indicator, RRE Code, TIN, SITE ID and to test receiving the CMS Missing Field Warning messages, companies must first be set up in ISO's membership database as CMS participants based on the information provided on the Authorization Forms.

For companies who wish to begin populating existing claims or to report new claims with fields required for CMS reporting, it is best to first participate in the ISO ClaimSearch CMS program. If your company will be using more than one RRE Code, TIN or SITE ID, each claim will need to include this information. You will not be able to include this information on your claims until you have been set up as an ISO ClaimSearch CMS participant.

NOTE: Third Party Administrators that are ISO ClaimSearch participants are authorized to participate in the ISO ClaimSearch Medicare Secondary Payer Program on behalf of their clients. It is necessary, however, that all insurers, self insurers, and self insured pools represented by a TPA be registered with CMS. CMS registration information (such as RRE codes, Account Manager's information and reporting periods) for companies that are not ISO ClaimSearch participants must be included in the Authorization Forms submitted to ISO by the TPA as part of the ISO ClaimSearch registration in the CMS program.

Third Party Administrators that report on behalf of companies that are ISO ClaimSearch participants, and have registered on their own for the ISO Medicare Secondary Payer program will need to report only the RRE code of those companies. Acknowledgement, Rejection and Query file results will be returned to the Account Management section of ISO ClaimSearch under the RRE code of the participating company filed on the submitted report.

Changes to Your Reporting Structure

Once you have signed up with ISO and have provided your RRE codes, TINs, SITE IDs and reporting period, it is important to keep ISO informed of any changes to your reporting structure. ISO can only query and report claims that can be identified by an RRE code. If you have added additional RRE codes, ISO must be notified in order for CMS reporting to occur. In addition, ISO will automatically build the TIN Reference File required by CMS based on the information you provided during registration with ISO. If any changes are needed to your TINs or SITE IDs, you must notify ISO in order for the proper information to be sent in your TIN Reference File.

Annual Review of the Profile Report

As of January 2012, CMS will e-mail the RRE's profile report to the Authorized representative annually, based on the receipt date of the last signed profile report. The RRE will be asked to confirm via e-mail to CMS that their current information is correct. Failure to confirm this information may result in deactivation of the RRE ID by CMS.

DETERMINING MEDICARE ELIGIBILITY (QUERY) OVERVIEW

To help companies identify Medicare-eligible claimants, every month ISO will provide an optional query of the CMS database for each participating RRE. Companies who have chosen ISO to be their agent may choose to have ISO always perform the query, or companies may choose to do the query themselves. Only one query file per month is allowed per RRE, so if you choose ISO to do the query for your company, you cannot also perform a query on your own.

Using the HEW software provided by CMS, the ISO ClaimSearch system will query your company's entire history of claims existing on the ISO ClaimSearch database which qualify for CMS reporting against the CMS database. For querying purposes, all claims must contain the claimant's name, SSN or HICN, date of birth and gender and must be associated with an RRE code.

ISO will post the positive results of the query to the Account Management section of the ISO ClaimSearch website so users can log in to check the Medicare eligibility of claimants. ISO will post the individuals who were positively identified as being Medicare recipients. The system will provide that information in a text file format as well as in a Microsoft Excel spreadsheet. Once Medicare eligibility has been determined, it is each company's responsibility to update the claims with the Medicare-eligible Indicator set to "yes" to indicate which claims ISO ClaimSearch should send to CMS.

Which Claims Qualify For The Query?

ISO will query a customer's entire inventory of Monoline Casualty "legacy format" and/or Universal Format claims currently on the database, as long as they meet the criteria for querying. Currently ISO has casualty claims on the database with received dates going back to 1992.

In order for a query to be performed, the claim must have a workers' comp, no-fault or liability coverage type. See Appendix A for valid CMS coverage types.

Only claims with the following required fields may be queried:

- Claimant Name (*since this is an ISO required field, it will always be present.*)
- Gender (*if the gender was not reported, ISO will pass "unknown" to CMS. Legacy casualty claims do not have a gender field. If you wish to add gender to a legacy casualty claim, you may do so using the Pre-Query Extract File process mentioned below.)*
- Date of Birth (DOB)
- Social Security Number (SSN) or Health Insurance Claim Number (HICN)
- RRE Code (if your group, company or office location has more than one RRE assigned or if your ISO ClaimSearch membership is a TPA).

If your company currently reports the status of the claim as "closed" with the closing date, any ORM claims which were closed *prior* to January 1, 2010 and any TPOC claim closed *prior* to October 1, 2011 will not be queried. If you do not report the status and closing date, ISO will assume the claim is still open and will perform the query. *(Legacy claims do not have a status or closing date field, so all qualifying legacy casualty claims will be queried unless you use the Pre-Query Extract File process mentioned below to indicate closed legacy claims).* Claims with closed dates *after* the threshold dates will continue to be queried.

Only claims that aren't already marked with the Medicare-eligible indicator set to "yes" will be queried. Once a claimant is marked as Medicare-eligible, ISO will no longer perform the query. The only way to stop the query is by marking the Medicare eligible indicator = "yes" or the Stop Query indicator, otherwise ISO will continue to query the claims each month.

Updating Existing Claims for the Query – Pre-Query Extract File Overview

Participants in ISO's Medicare Secondary Payer (MSP) Reporting Service must identify which pending claims previously submitted to ISO ClaimSearch must be reported to CMS to assure compliance with the requirement to report all injury claims filed by Medicare-eligible claimants.

As part of the MSP Reporting Service, ISO ClaimSearch will automatically query your submitted claims against the CMS Medicare Eligibility database each month to help you identify Medicare-eligible claimants.

In order to submit queries to its database, CMS requires certain fields of information on each claim: Claimant Name; SSN or HICN; Gender; and Date of Birth and RRE code (if more than one or if your ISO ClaimSearch membership is a TPA).

Since claims may have been reported to ISO ClaimSearch without some of the fields required for the CMS query, ISO will provide, upon request, an extract file of all of your company's injury claims contained in the ISO ClaimSearch database.

This full inventory of claims will allow you to identify:

1. Closed claims that do not need to be reported to CMS
2. Open claims that should be queried against the CMS database to find out if the claimant is a Medicare recipient
3. Claims missing data elements required by CMS for queries or reports
4. The format of the claim report submitted to ISO ClaimSearch – legacy or Universal Format. Both types can be queried with CMS, but only claims in Universal Format can be reported to CMS. You will need to convert all claims in legacy format with Medicare-eligible claimants to Universal Format for reporting to CMS.

Here is how the Pre-Query Extract process will work. The pre-query extract file will provide:

- Information helpful to ISO for internal purposes (ClaimSearch Identifier, Person Number, Run Type).
- Basic information regarding the claim (Company/Office Code, Claim Number, Policy Number, Date of Loss).
- Information regarding whether required fields for the query are present on the claim (Claimant Name (always present), Date of Birth, SSN, Gender (a gender of unknown will be sent to CMS if the gender is not provided).
- The Policy/Coverage/Loss Type will be shown, as well as an indicator to let you know if the type is CMS-Reportable.
- An Indicator showing if the claim was reported in the Legacy Format or Universal Format. Legacy claims can be queried, but must be converted to Universal Format if the person is a Medicare recipient and the claim needs to be reported to CMS.
- The claim status of Open or Closed (if reported), as well as the Closing Date (if reported). ISO ClaimSearch will not query any ORM (No-Fault or WC) claims that can be identified as being closed prior to 1/1/10, and will not query any TPOC (Liability) claims that can be identified as being closed prior to 10/1/11.

As part of this process, customers can update the file to include the necessary information and return it to ISO to allow the CMS query process to be performed. Note that customers that plan to report to CMS using multiple Responsible Reporting Entity (RRE) codes will also need to indicate the applicable RRE code for each claim.

ISO will charge a fee to extract this file, send it to you for review and updating, receive your updated file, and prepare it for the CMS query process. Please contact claimsearch.sales@iso.com to obtain pricing information and an authorization form to request the extract file.

Pre-Query Extract File Processing Details

The Pre-Query Extract File Process may serve multiple purposes for customers using ISO to perform the monthly query of claims/claimants against the CMS file to identify Medicare recipients.

1. It may be used only for informational purposes to see which claims are currently on the ISO ClaimSearch database, evaluate whether those claims are the appropriate types to be queried, and whether the data fields required for the query are available.

2. Some customers may not want to update individual claims with missing information simply for the query. The extract process would allow them to provide ISO with the necessary information to perform the query in a simple one-file process. *Please note that providing the information to ISO through this format will not update the actual claim on the database.* This process will allow ISO only to perform the query. If a claimant is found to be Medicare-eligible, the actual claim must also be updated with the necessary fields before being reported to CMS.

3. If a company has registered more than one RRE code for a group, company or office, each claim must be identified with the correct RRE in order for the query to be run. Providing the RRE code in the file that is returned to ISO will allow ISO to query the claims in the correct RRE file. If a company registers only one RRE, it is not necessary to provide the RRE code on each claim because ISO will be able to derive it from our membership system. However, TPAs must report the RRE code on each claim to be queried and/or reported to CMS even if they only have one RRE code assigned.

If the customer wishes to append the RRE code or any of the required fields for the query, or wants to supply the closing date in order to stop the query process, the customer can send the file back to ISO with the applied fields populated. The applied fields include: RRE Code, SSN, Date of Birth, Gender, Open/Closed Indicator and Closed Date.

NOTE: Providing information in this format will populate *only* the query table; it will not add the fields to the actual claim. If a claimant is identified through the query to be a Medicare recipient, any additional fields will need to be added by the customer to the actual claim, along with the Medicare- Eligible Indicator for reporting the claims to CMS.

In order for the query to be performed, *all* of the required fields for each claimant must be added *either* through this process *or* by updating the claim on the database. The query cannot be performed if some of the fields are added through this process and others are added directly to the claim. The query can only be performed if all of the fields are included in the claim record in the database, or if all of the fields are added through this process -- not using a combination of the two.

Two files will be created: one is a fixed-length text file and the other is an Excel file. The files contain identical information. If you wish to append the RRE code or any of the required fields for the query, or want to supply the closing date in order to stop the query process, you may send the file back to ISO with the applied fields populated. If you return the flat file (.txt), the new information should be included in positions 203-242 in the attached record layout. If you would like to send back the Excel spreadsheet, please include the applied information in columns A (RRE), O (date of birth), S (SSN), U (open/closed indicator) and W (closed date). Do not alter the file layout in any way; if there are any claims you do not need to update, you may remove the claim in its entirety when returning it to ISO ClaimSearch. Either the fixed length or the Excel file may be sent back to ISO with appropriate changes.

Please see Appendix G for the file layout which will identify the fields that will be provided to the customer, as well as the fields that the customer may apply to the file to update ISO's query tables. Extract files are available in a fixed width format or in a delimited file format.

Pre-Query Extract File Instructions

1. To request a Pre-Query Extract file, please complete an Authorization Form and return it to ISO following the instructions on the Form. If you have any questions or need to obtain an Authorization Form, please contact your ISO Account Manager or Account Executive at 1-800-888-4476 or send an e-mail to claimsearch.sales@iso.com.

2. When the file is ready, your company's technical contact as listed on the Pre-Query Extract Authorization Form will be notified via e-mail. The extract file will be placed in a secure FTP directory for you to retrieve. You will be provided with a URL, ID and Password to log in to download the file.

3. The first "history" extract will contain all claims on the database up to the point that the file is created.

4. Future extracts may be done based on a specific date range for an additional charge.

5. If you would like to add new information to the file and return it to ISO so that we can add it to the query table, place the file in the same FTP directory with a file name of "New Information." Send an e-mail to claimsearchdatabasedevelopment@iso.com to let us know that the file has been uploaded.

Results of Query File

ISO will send the monthly query files for each RRE to CMS on the first Sunday of each month. All claims to be included in the query must be entered into the ClaimSearch system by the day before the file is created on the first Sunday of the month. Once ISO sends the query file to CMS, it may take CMS up to 14 days to respond. When ISO receives the results from CMS, we will post the results to the Account Management section of the ISO ClaimSearch website so authorized users can log in to download a file containing the claimants which were positively identified as being Medicare recipients. Only users with access to this specific file will be able to log in. To obtain access for users, please complete the Authorization Forms provided in your ISO registration package. ISO will send an e-mail to the RRE's Account Manager informing them that the file has been posted.

Below is a screen shot of what the Account Management screen looks like:

ISO ClaimSearch CMS Reports

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For reports questions, please call 201-469-3159, or send an e-mail to cmsreports@iso.com

RRE Code: Report Type:

Query Reports

Date	Excel File	TEXT File	Download
9/16/09	QUERY_000012133_09162009_01.csv	QUERY_000012133_09162009_01.txt	Complete

Users with access to download files for multiple RREs will see a drop down where they may select the RRE code for the file they wish to download. There will be a drop-down for a user to choose whether they are selecting the quarterly Error and Acknowledgement files or the monthly Query Result Files. Customers may choose to download either the Excel File or the Text File.

When you click on the link, the files will be in a .zip file and when you extract the file, it will be either a .csv or .txt file.

Files will remain on the website for two years.

Below are the file names of the query result files that will be posted to the Account Management page of the ISO ClaimSearch website.

1. Zip file name (csv)– Query_<RRECode>_<date (MMDDYYYY)>_<sequence number>_csv.zip
2. CSV file name – Query_<RRECode>_<date (MMDDYYYY)>_<sequence number>.csv
3. Zip file name (txt)– Query_<RRECode>_<date (MMDDYYYY)>_<sequence number>_txt.zip
4. TXT file name - Query_<RRECode>_<date (MMDDYYYY)>_<sequence number>.txt

Examples:

Query_999999999_10162009_01.csv.zip

Query_999999999_10162009._01.csv

Query_999999999_10162009_01.txt.zip

Query_999999999_10162009._01.txt

NOTE: Large files will be broken up into multiple smaller files. The sequence number 01, 02, etc...will be added to distinguish multiple smaller files for the same date.

NOTE: *Some companies have asked if the file download process can be automated. At this time, it is not possible; an actual user must log into the site to download the file. ISO will consider a future enhancement to return the query result files via FTP.*

The file will contain only individuals that were identified as Medicare recipients; it will not contain all of the individuals that were queried. ISO will maintain in its internal logs the first date a query was performed and the most current date that a query was performed in an audit trail in case it ever becomes necessary to prove that individuals were queried.

See Appendix B for the layout of the query result file.

Timeline for Beginning Queries

ISO began sending querying production files for customers who have completed the ISO registration process in November 2009. ISO will query all claims currently on the production database that qualify for the query and will provide the results as described above. Customers should use these results to update claims that need to be reported to CMS with the Medicare eligible indicator = yes and other CMS required fields for reporting.

As mentioned above, ISO has been querying claims since November 2009. If your company has not received query results yet, it could be for several reasons:

1. You have not reported any applicable type claims to ISO ClaimSearch with all the required fields for querying. (The only required fields which may be missing are the SSN or HICN and Date of Birth since the Name is required by ISO ClaimSearch and a Gender of "unknown" is acceptable).
2. Your group, company or office has multiple RRE codes, so ISO cannot derive the code for you and you have not added the RRE code to each claim to be queried.
3. You report through a TPA and the TPA hasn't added the RRE code to each claim to be queried.
4. Your query transmissions are failing due to missing designees or improper or incomplete registration with CMS.

CLAIMS REPORTING OVERVIEW

Reporting to Medicare through ISO is through enhancements and adaptation of the existing ISO ClaimSearch Universal Format reporting method. Claims to be reported to CMS must be accepted in ISO ClaimSearch before any CMS query or reporting processes can take place. Claim reports that are rejected from ClaimSearch reporting must be corrected and re-submitted to ISO ClaimSearch to be queried by, or submitted to CMS. ISO does not provide the ability to report direct to CMS without reporting to ISO ClaimSearch. Simply report claims as usual to ISO ClaimSearch using Universal Format, and notify ISO of the Medicare-eligible claimants including the CMS required data elements. ISO ClaimSearch will forward any Medicare-eligible claimants to CMS automatically. ISO ClaimSearch will send the claim reports to CMS according to the schedule established by CMS for each responsible reporting entity (RRE).

Companies will be able to report and update claims using either system-to-system connections to ISO ClaimSearch or the ISO ClaimSearch web reporting application. The ISO ClaimSearch website contains all of the data fields CMS requires, and companies will see an indicator next to the CMS-required fields.

ISO ClaimSearch Required Fields for Casualty Claims

In order to add a claim to the ISO ClaimSearch database, the following fields are required. Some of these fields are also used in reporting to CMS as indicated below. See Appendix F for the mapping of ISO fields to the CMS layout.

- **ISO Reporting Code** – will be linked to RRE codes provided in ISO registration process.
- **Claim Number** – Claim Number will be reported to CMS.
- **Policy Number** – Policy Number will be reported to CMS.
- **Date of Loss** (not to be confused with CMS Date of Incident) – Date of Loss will be reported to CMS as the Industry Date of Incident.
- **Insured Name** - Insured name will be reported to CMS.
- **Insured Address** (Street, City, State) – These fields are NOT reported to CMS.
- **Claimant Name** (may be the same as the insured) – Claimant Name is a CMS-required field.
- **Claimant Address** (Street, City, State) - These fields are NOT reported to CMS.
- **Alleged Injury** (as described by claimant) - The injury to the involved party (up to 50 characters). This field is required by CMS through 12/31/10 if there is no Alleged Cause of Illness/Injury Code or ICD-9 Code provided. As of 1/1/11 ISO is no longer passing this field to CMS, but you must continue to report this field on your ClaimSearch Universal Format reports because this field is still required by ClaimSearch.
- **Location of Loss State** – This field is NOT reported to CMS.

ISO ClaimSearch Optional Fields Required for CMS Reporting

- **Gender** - Gender is a CMS-required field. If no gender is reported, ISO will pass "unknown" which is an acceptable gender for CMS reporting.
- **Date of Birth** – Date of Birth is a CMS-required field.
- **Social Security Number** – SSN is a CMS-required field, unless the HICN is reported.
- **Service Providers (Representatives)** – Roles for representatives that may be reported as Service Providers to ISO include the legal roles (Claimant Lawyer, Insured Lawyer, Law Office, Law Office Manager, Lawyer-Other, Paralegal, Lawyer for CMS), Guardian, Power of Attorney and Other. Fields that will be sent to CMS include the individual name, business name, TIN,

CLAIMS REPORTING OVERVIEW

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- **Insured Name** - Insured name will be reported to CMS.
- **Insured Address** (Street, City, State) – These fields are NOT reported to CMS.
- **Claimant Name** (may be the same as the insured) – Claimant Name is a CMS-required field.
- **Claimant Address** (Street, City, State) - These fields are NOT reported to CMS.
- **Alleged Injury** (as described by claimant) - The injury to the involved party (up to 50 characters). This field is required by CMS through 12/31/10 if there is no Alleged Cause of Illness/Injury Code or ICD-9 Code provided. As of 1/1/11 ISO is no longer passing this field to CMS, but you must continue to report this field on your ClaimSearch Universal Format reports because this field is still required by ClaimSearch.
- **Location of Loss State** – This field is NOT reported to CMS.

ISO ClaimSearch Optional Fields Required for CMS Reporting

- **Gender** - Gender is a CMS-required field. If no gender is reported, ISO will pass "unknown" which is an acceptable gender for CMS reporting.
- **Date of Birth** – Date of Birth is a CMS-required field.
- **Social Security Number** – SSN is a CMS-required field, unless the HICN is reported.
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Timeline for Beginning Queries

ISO began sending querying production files for customers who have completed the ISO registration process in November 2009. ISO will query all claims currently on the production database that qualify for the query and will provide the results as described above. Customers should use these results to update claims that need to be reported to CMS with the Medicare eligible indicator = yes and other CMS required fields for reporting.

As mentioned above, ISO has been querying claims since November 2009. If your company has not received query results yet, it could be for several reasons:

1. You have not reported any applicable type claims to ISO ClaimSearch with all the required fields for querying. (The only required fields which may be missing are the SSN or HICN and Date of Birth since the Name is required by ISO ClaimSearch and a Gender of "unknown" is acceptable).
2. Your group, company or office has multiple RRE codes, so ISO cannot derive the code for you and you have not added the RRE code to each claim to be queried.
3. You report through a TPA and the TPA hasn't added the RRE code to each claim to be queried.
4. Your query transmissions are failing due to missing designees or improper or incomplete registration with CMS.

address and phone number of the service provider (representative). The name, address and phone number are required by CMS. Since CMS only allows one representative and ISO ClaimSearch allows multiple, we will use a hierarchy when choosing which representative to send to CMS. If the "Lawyer for CMS" role is chosen, that representative will automatically be sent to CMS even if required fields are missing. If no "Lawyer for CMS" role exists, we will look for any other lawyer that has all CMS required fields and will send the first one we find with complete information. If no lawyers with complete information exist, we will look for the first guardian, power of attorney or other role we find with all CMS required fields.

CMS Required Fields (Recently Added to ISO ClaimSearch)

All CMS fields that were not already included in ISO ClaimSearch have been added to the Universal Format and XML layouts and to the ISO ClaimSearch data-entry website. These fields are currently in ISO's test and production environments. The additional CMS fields which were added are optional, as the ISO ClaimSearch process is primary.

The additional data elements added at the claim level include:

- **Self Insured Indicator** - to be used by TPAs; for insurers and non-insurers, this will be derived by your company's membership to ISO ClaimSearch. TPAs should report "YES" if it is a self-insured claim and "NO" if it is not a self-insured claim.
- **COBC Assigned Section 111 Reporter ID (RRE Code)** - If you are an insurer or self-insured company (group, company or office) with only one responsible reporting entity (RRE) code registered at either the group, company or office level, you do not need to report this information on each claim; it will be stored in ISO's membership system and will automatically be associated with each claim. *If your group/company/office has more than one RRE code, you will need to populate this field on each claim to be queried or reported to CMS. TPAs will always have to report the RRE code, even if the TPA has only one RRE code associated with it.*
- **TIN** - For insurers and self-insured companies, if your group/company/office has only one TIN registered for each RRE, you do not need to report this information on each claim; it will be stored in ISO's membership system and will automatically be associated with each claim. *If your group/company/office has more than one TIN, you will need to populate this field on each claim to be reported to CMS. TPAs will always have to report the TIN, even if a TPA has only one TIN associated with it.*
- **SITE ID** - For insurers and self-insured companies, if your group/company/office has only one SITE ID associated to a particular TIN, you do not need to report this information on each claim; it will be stored in ISO's membership system and will automatically be associated with each claim. *If your group/company/office has more than one SITE ID per TIN, you will need to populate this field on each claim to be reported to CMS. TPAs will always have to report the SITE ID, even if a TPA has only one SITE ID associated with it.* SITE ID is a numeric only field.

  NOTE: *RRE Codes, TINs and SITE IDs are maintained in ISO's membership system. ISO must be notified of any additions or changes to these codes/IDs.*

The additional data elements added at the claimant level include:

- **Medicare Eligible Indicator** - This field should be populated with "YES" if you are aware that this involved party is Medicare eligible and if you would like this claimant to be reported to CMS. You

may choose "NO" if you wish to report that the person is not Medicare eligible, or you can leave this field blank for any claimants that do not need to be reported to CMS. Entering "YES" will stop the monthly query on this party. The Medicare eligible indicator = "yes" is the main trigger for CMS reporting. Only claimants marked with this indicator will be reported to CMS.

- **'Do Not Send this party to CMS' Indicator** - If you mark the claimant as Medicare Eligible = "YES" but do not want the claim sent to CMS, you may send the 'Do not send this party to CMS' indicator. You may do this because the claim amount is below the required dollar threshold, coverage has not been confirmed, or if you do not have all required fields and do not want to receive a CMS rejection. If this indicator is checked, this claimant will not be reported to CMS until the indicator is removed. Please note that this indicator does not stop the person from being queried. If you enter this indicator after the claim has been sent to CMS, ISO will send a delete transaction to CMS.
- **Injured Party HICN**-This field allows you to enter the Medicare Health Insurance Claim Number (HICN), for the injured party on a claim. HICN is required if the SSN is not reported. CMS advises that once a HICN is provided through a query response file, it must be used on all future submissions. You must add the HICN to your claim on the ClaimSearch database in order for it to be reported on future submissions.
- **Stop Querying CMS to determine Medicare eligibility for this party** – This field allows you to choose when to stop querying a claimant for eligibility outside of the parameters in which ISO normally stops querying. You may wish to stop the query if the claim is closed and you do not expect to have further responsibility.

The additional elements added at the coverage level include:

- **Date of Incident (DOI) as defined by CMS:** For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure (including, for example, Occupational Disease and any associated cumulative injury) the CMS DOI is the date of first exposure. For claims involving ingestion (for example, a recalled drug), it is the date of first ingestion. For claims involving implants, it is the date of the implant (or date of the first implant if there are multiple implants). The CMS Date of Incident for these claims is often different than the date of loss or incident used by insurers under current practice, which generally involves last exposure.
- **State of Venue** - Enter the US Postal abbreviation corresponding to the state whose law controls resolution of the claim such as in certain no-fault statutes. Insert "US" where the claim is a Federal Tort Claims Act liability insurance matter or a Federal workers' compensation claim. Enter "FC" in the case where the State of Venue is outside the United States. The state of venue may be different than the Loss Location field in ISO ClaimSearch.
- **No Fault Insurance Limit** - This field requires that you enter the dollar amount of the limit on no-fault insurance. Please do not enter dollar signs, commas, or decimals. Dollars and cents are to be reported. Fill with nines if there is no dollar limit such as a workers' compensation no-fault state with a time limit or monetary policy limit. Leave blank if Plan Insurance is Workers Compensation or Liability Insurance (including Self-Insurance). "No Fault" Insurance means insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans.
- **Exhaust Date for Dollar Limit for No-Fault Insurance** - This field allows you to enter the date on which the limit was reached or benefits exhausted for No-Fault Insurance. Leave blank if No-

Fault limit has not been reached/exhausted or if the Plan Insurance Type is Workers Compensation or Liability Insurance (including Self-Insurance). This field should not be populated until the No-Fault insurance limit is exhausted. It should not be a future date.

- **On-Going Responsibility for Medicals (ORM) Indicator** - This field should be used to indicate if there is an ongoing responsibility for medicals. Report 'YES' if you do have ongoing responsibility and 'NO' if you do not have ongoing responsibility. This field is passed to CMS, but is not used by ISO to determine whether to send your claim according to the ORM or TPOC rules. ISO derives whether your claim should be treated as ORM or TPOC based on the policy, coverage and loss type reported. Based on recent errors seen on CMS result files, ISO will no longer send claims which are mapped to an ORM policy, coverage and loss type to CMS if you mark the ORM Indicator as "NO". The claim will not be sent until you change the indicator to "YES" or report a TPOC date.
- **On-Going Responsibility for Medicals (ORM) Termination Date** - This field should be populated with the date that the ongoing responsibility for medicals ended, where applicable. This field should only be entered if you have previously checked this claim as an ORM. An ORM termination date may not be the date the claim is settled. It is the period of time in which a policy will respond for claims for the same incident. Future dates are accepted but should not be more than 6 months greater than the file submission date. *For ORM claims, the claim will be sent to CMS as an ADD record when the claimant is first marked as Medicare eligible, and it will be sent as an UPDATE record when the ORM Termination Date is provided.*
- **Total Payment Obligation to the Claimant (TPOC) Date** - (Max 5) - Date payment obligation was established through settlement, judgment, award or other payment; this is the date the obligation is signed if there is a written agreement, unless court approval is required. If court approval is required, it is the later of the date the obligation is signed or the date of court approval. If there is no written agreement (settlement), it is the date of the first payment when there will be multiple payments or settlement date when there is only one settlement payment. If you have more than 5 TPOCs, the 6th and subsequent TPOCs should be added to TPOC 5. The most recent date should be reported in the TPOC 5 date field. *For TPOC claims, the claim will be sent to CMS as an ADD record when both the claimant is marked as Medicare-eligible and the TPOC Date is provided.*
- **Total Payment Obligation to the Claimant (TPOC) Amount** - (Max 5) – This field is to be filled with the settlement amount of the claim for the claimant. In regards to the TPOC Amount, if there is a structured settlement, the amount is the total payout amount. If a settlement provides for the purchase of an annuity, it is the total payout from the annuity. For annuities base the total amount upon the time period used in calculating the purchase price of the annuity or the minimum payout amount (if there is a minimum payout), whichever calculation results in the larger amount. Please do not enter dollar signs, commas, or decimals. Dollars and cents are to be reported. If you have more than 5 TPOCs, the 6th and subsequent TPOC amount should be added to TPOC 5. In most cases, the TPOC amount is the settlement amount.
- **Funding Delayed Beyond TPOC Start Date** - (Max 5) - If funding for the Total Payment Obligation to the Claimant is delayed, provide the actual or estimated date of funding. Fill with zeroes if not applicable. If you have more than 5 TPOCs, the 6th and subsequent TPOCs should be added to TPOC 5. The most recent date should be reported in the 5th Funding Delayed field.
- **ICD-9 Codes** - (Max 19) (Internal Classification of Diseases, Ninth Revision, Clinical Modification) Diagnosis Code describing the alleged injury/illness. CMS requires five (5) digit ICD-9 Codes. The ISO ClaimSearch field is defined as six (6) digits. When entering this field, you may include the decimal. If you do, the decimal will be stripped on the file sent to CMS. If an ICD-9 code is less than five digits, ISO will send the appropriate number of spaces at the end of the code to

equal the required five bytes. CMS requires at least one ICD-9 Diagnosis code for new or updated records submitted on or after 1/1/11. At least one valid diagnosis code must be sent and it must not be an E code and not be a V code. CMS will review the accuracy of ICD-9 codes to injuries provided, so care in selection is recommended. Please refer to CMS's list of insufficient ICD-9 Diagnostic Codes in Appendix H of CMS's manual (Version 3.1). ISO compiled and condensed the reportable ICD-9 (including the new NOINJ code to be used in rare instances to report "no injury") codes into an Excel spreadsheet available on the ISO ClaimSearch website. The list includes all revisions to the ICD-9 codes that CMS allows. In addition, in ClaimSearch claims reporting, ISO developed a look up function where a user entering or updating a claim, can search for an ICD-9 code based on a word or a phrase. ISO developed these features based on the CMS recommended reference sites:
http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf,
http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm,
www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp
NOTE: For customers with system-to-system interfaces using the Universal Format text file layout, if ICD9 codes are reported on both the UC01 record and UEX3 record, the codes from the UEX3 record will be sent to CMS. If less than 19 ICD9 codes are reported on the UEX3, remaining ICD9s would be populated from the UC01 record.
SEE APPENDIX H FOR MORE TIPS ON REPORTING ICD-9 CODES

- **Alleged Cause of Injury Code** - Enter the ICD-9-CM External Cause of Injury Code, "E Code" describing the alleged cause of injury/illness. CMS requires five (5) digit Cause of Injury Codes. Do not enter the decimal. If a Cause of Injury code is less than five bytes, ISO will send the appropriate number of spaces at the end of the code to equal the required five bytes. CMS requires the Cause of Injury code on all new or updated records submitted on or after 1/1/11. Please refer to CMS' list of insufficient ICD-9 Diagnosis codes in Appendix H of CMS's manual (Version 3.1). ISO compiled and condensed the reportable ICD-9-CM (including the NOINJ code) codes into an excel spreadsheet available on the ISO ClaimSearch website. The list includes all revisions to the ICD-9-CM codes that CMS allows. In addition, in ClaimSearch claims reporting, ISO developed a look up function where a user entering or updating a claim, can search for an ICD-9-CM code based on a word or a phrase. ISO developed these features based on the CMS recommended reference sites:
  http://www.cdc.gov/nchs/icd/icd9cm.htm
  http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp
  SEE APPENDIX H FOR MORE INFORMATION ON REPORTING CAUSE OF INJURY CODES.
- **Delete this party/coverage from CMS Indicator** – Marking this field as "YES" will send a delete transaction to CMS for this individual. CMS instructs that the delete transaction should only be used in rare instances when an original record should never have been sent in the first place. If you mark this indicator prior to your claim being sent to CMS, ISO will not send the claim to CMS.
- **Do not send this coverage to CMS Indicator** – Marking this field as "YES" will prevent this claimant/coverage from being sent to CMS. You may do this because the claim amount is below the required dollar threshold, coverage has not been confirmed, or if you do not have all required fields and do not want to receive a CMS rejection. If this indicator is checked, this claimant/coverage will not be reported to CMS until the indicator is removed. Please note that this indicator does not stop the person from being queried. If you enter this indicator after the claim has been sent to CMS, ISO will send a delete transaction to CMS.
- ***Product Liability Indicator** - If the involved party is injured as a result of or involves a defective product, you may indicate this by selecting 'YES, this claim is a product liability but not a mass

tort' or 'YES, this claim is a mass tort claim and a product was involved in the injury' or 'NO' if this is not a product liability claim. Note: product liability claims should be entered as coverage and loss type when reporting the claim to ClaimSearch. The indicator (which is currently not required by CMS until further notice) may reflect a product defect which may be contributory to a claim for Workers' Compensation or No-Fault.

- ***Product Generic Name** – The generic name of the product alleged to be the cause of injury, illness or incident. If no generic name is applicable, supply the brand name. .
- ***Product Brand Name** – The brand name of the product alleged to be the cause of injury, illness or incident. .
- ***Product Manufacturer** – The maker of the product. .
- ***Product Alleged Harm** - This is a free-form text field that provides the opportunity to enter a more detailed description of the harm allegedly caused by a product (maximum 200 characters). This field is required by CMS now if the Product Liability is a mass tort situation.

*The requirements for Fields 58-62 on the Claim Input File Detail Record are currently under review by CMS. These fields will be filled with spaces by ISO until revised requirements are published.

You will note that some fields appear either duplicative or contradictory, such as the CMS Date of Incident vs. Date of Loss or TPOC Amount vs. Settlement Amount. CMS' fields of information are defined differently than those in ISO ClaimSearch. We have added the CMS fields for entry, as opposed to mapping fields with different interpretations.

A mapping of ISO claim reporting fields to CMS reporting fields is included in Appendix F.

See the Universal Format Manual version 7.3 for the layout for Universal Format FTP and MQ customers.

See the XML Manual version 5.3 for the XML specs.

See the User Manual for CMS Reporting Version 3.3 for the instructions to report CMS claims via the ISO ClaimSearch website.

Required Field Warnings

We have added a "CMS required field" warning notification to the ISO ClaimSearch output records and match reports to notify participants of missing or invalid CMS required fields.

When companies mark claimants as Medicare-eligible, the system will screen the claims to identify missing or in some cases, invalid CMS-required fields. If fields are missing or invalid, ISO ClaimSearch will provide a warning indicator. For companies who receive web returns, the warning indicator will show on the SUMMARY SCREEN indicated by a red exclamation point. See below:

Reports | Claim Submission | APD FastCheck | Preferences

'Submitted Report +' means that no matching claims were found, however, NCIC and/or Shipping information is contained within the report.

Your office has unread reports more than 15 days old. Click 'View All Office Reports' to see these reports.

Print New | Print Selected | Delete Selected | View All Office Reports

	Select	Report Date	Type	Adjuster	Score	Claim Number	Routing
1)	☐	07-10-2009	Match Report	BERKOWITZ,BRYAN,L		12313 NEW !	
2)	☐	07-10-2009	Match Report	BERKOWITZ,BRYAN,L		12313 !	
3)	☐	07-10-2009	Submitted Report Only	BERKOWITZ,BRYAN,L		12345 !	
4)	☐	07-10-2009	Match Report	BERKOWITZ,BRYAN,L		12313	

For web, PDF or XML customers who use the style sheets provided by ISO, the warning message(s) will appear within the ISO ClaimSearch match report in the summary section for the involved party. See the example below in which Matthew Bryant was reported as Medicare-eligible and has warning messages for missing SSN or HICN.

Reports | Claim Submission | APD FastCheck | Preferences

Print Back to reports list

ISO CLAIMSEARCH MATCH REPORT SUMMARY

A claim report identified by ClaimSearch identification number 8I000442918 was received by ISO ClaimSearch on 7/9/2009 as a Replacement of a previously submitted claim. Submission of this replacement claim initiated a search of the ClaimSearch database. The claim(s) listed below appear(s) to be similar to the claim submitted. Reasonable procedures have been adopted to maximize the accuracy of this report. Independent investigations should be performed to evaluate the relevant data provided.

If you have any questions concerning your report, please contact Customer Support at (800) 888-4476.

INITIATING CLAIM INFORMATION

Claim Number: 12313 **Date of Loss:** 06/16/2009
Policy Number: 12313 **ISO File Number:** 8I000442918

SUMMARY FOR EACH SEARCHABLE PARTY

BOB'S CONSTRUCTION, INSURED
No matches for this party

MATTHEW BRYANT, CLAIMANT
** This Person is Medicare Eligible. **

Coverage: Indemnity **Loss Type:** Indemnity
Missing CMS Required Field: Injured Party HICN or Injured party SSN is required

If your company participates in the optional ClaimDirector service, the warnings will appear within the actual match report since ClaimDirector result reports do not have the summary shown above.

For customers who receive FTP or MQ returns, the warning messages will appear on the MCMS record. Your company will need to do additional programming to read this new record type. For XML customers, the warning messages will appear on a new aggregate, CMS Warning <com.iso_CMS>.

If an invalid entry is sent to ISO ClaimSearch for one of these fields (ex: if all 9s are submitted as an SSN), that field will be blanked out by ClaimSearch. These fields will be considered blank for CMS purposes and will be subject to the CMS warning messages.

The system will provide the warning when the company first marks the claim as Medicare eligible and each time the company replaces the claim to add additional information. Because the warnings are shown on match reports, they will not be generated if the 'Submit Claim Only – Do Not Search' indicator is checked on the web or if the 'No Search' indicator is checked for system-to-system companies since no match reports are generated in those instances. Warnings are also not generated when the update transactions are used vs. the replacement transactions (for system-to-system companies) because updates do not perform searches or generate match reports. At this time, warnings are also not provided on Research records; ISO will consider this as a future enhancement. Currently, warnings only occur for searchable involved parties submitted on Initials or Replacements.

The warning indicators will give your company the chance to update the claim with the missing fields before the scheduled CMS quarterly submission period. The warnings do not prevent the claims from being sent to CMS at the designated reporting period, however. If the fields are not added to the claims, the reports will still be sent to CMS as part of the quarterly reporting requirement.

ISO ClaimSearch is not validating all fields based on CMS edits. ISO does not know all of the validations that CMS may perform on required fields. The warnings are to provide you with information on missing CMS required fields or fields with apparent invalid values; it is not a guarantee that CMS will accept your claim once these fields are provided.

NOTE: *Some customers do not want claims to be sent to CMS that they know will reject. If your company does not want claims to be sent to CMS that you know will reject, you may check the 'Do not send to CMS Indicator' to prevent the claim from being sent.*

The screening service includes rules for reporting contingent fields. This means that if certain conditions exist, there is a requirement to report these conditions to CMS through ISO ClaimSearch. For example, information on the claim representative isn't always required, however, if your company reports a representative such as an attorney, the individual or business name and address and phone number are required.

See next page for a complete list of required field warnings.

NOTE: In the case of multiple additional claimants or multiple representatives for an injured party or additional claimant, ISO is unable to indicate which specific parties are missing the required information; it may be only one party, or it may be multiple parties. The messages below (06-13, 28-42) alert you to the fact that at least one party is missing information. In some instances, that party may not be the individual that will be sent to CMS. EX: CMS can only accept one Representative for an Injured Party or Additional Claimant. ISO uses a hierarchy in deciding which Representative to send to CMS. For example, if a lawyer and guardian are sent on input, only the lawyer will be sent to CMS. In this example, the lawyer may or may not be the individual the warning was generated for.

ISO has also created a management report to provide users with access to any claims that contain the ISO ClaimSearch CMS warnings. This report gives users the ability to see which claimants they have marked as Medicare eligible but have missing CMS required fields. For further information, see the ISO ClaimSearch MSP Account Management section of this manual.

CMS REQUIRED FIELD WARNINGS GENERATED BY ISO CLAIMSEARCH

Code	Warning Message
01	RRE Code Missing or Invalid
02	TIN Missing or Invalid
03	Site ID Missing or Invalid
04	Injured Party HICN or Injured party SSN is required
05	Injured Party DOB missing or Invalid
09	One or more Injured Party Representative Mailing Address Missing or Invalid
12	One or more Injured Party Representative Zip Code Missing or Invalid
13	One or more Injured Party Representative Phone Missing or Invalid
14	Self Insured indicator Missing or Invalid – required for liability & workers comp claims (required only for TPAs).
15	Date of Incident Missing or Invalid
16	State of Venue Missing or Invalid
17	No-Fault Insurance Limit Missing or Invalid
18	ORM Indicator Missing or Invalid
19	TPOC Amount Missing or Invalid
20	Alleged Cause of Injury, Incident or Illness Missing or Invalid
21	ICD-9 Diagnosis Code Missing
27	ICD-10 Diagnosis Code Missing or Invalid (future)
28	One or more Additional Claimant Individual/Business Indicator Missing or Invalid
29	One or more Additional Claimant Business Name Missing or Invalid
30	One or more Additional Claimant Last Name Missing or Invalid
31	One or more Additional Claimant First Name Missing or Invalid

Code	Warning Message
32	One or more Additional Claimant SSN or TIN Missing or Invalid
34	One or more Additional Claimant Mailing Address Missing or Invalid
35	One or more Additional Claimant City Missing or Invalid
36	One or more Additional Claimant State Missing or Invalid
37	One or more Additional Claimant Zip Code Missing or Invalid
38	One or more Additional Claimant Phone Missing or Invalid
40	One or more Additional Claimant Representative Mailing Address Missing or Invalid
41	One or more Additional Claimant Representative Zip Code Missing or Invalid
42	One or more Additional Claimant Representative Phone Missing or Invalid
44	TPOC date 1 must be greater than the CMS Date of Incident.
45	TPOC date 2 must be greater than the CMS Date of Incident.
46	TPOC date 3 must be greater than the CMS Date of Incident.
47	TPOC date 4 must be greater than the CMS Date of Incident.
48	TPOC date 5 must be greater than the CMS Date of Incident.
49	Total of all TPOC amounts is below dollar threshold
50	ICD-9 Diagnosis Code 1 is Invalid
51	ICD-9 Diagnosis Code 2 is Invalid
52	ICD-9 Diagnosis Code 3 is Invalid
53	ICD-9 Diagnosis Code 4 is Invalid
54	ICD-9 Diagnosis Code 5 is Invalid
55	ICD-9 Diagnosis Code 6 is Invalid
56	ICD-9 Diagnosis Code 7 is Invalid
57	ICD-9 Diagnosis Code 8 is Invalid
58	ICD-9 Diagnosis Code 9 is Invalid
59	ICD-9 Diagnosis Code 10 is Invalid

Code	Warning Message
60	ICD-9 Diagnosis Code 11 is Invalid
61	ICD-9 Diagnosis Code 12 is Invalid
62	ICD-9 Diagnosis Code 13 is Invalid
63	ICD-9 Diagnosis Code 14 is Invalid
64	ICD-9 Diagnosis Code 15 is Invalid
65	ICD-9 Diagnosis Code 16 is Invalid
66	ICD-9 Diagnosis Code 17 is Invalid
67	ICD-9 Diagnosis Code 18 is Invalid
68	ICD-9 Diagnosis Code 19 is Invalid
69	TPOC claim has ORM indicator = Y. Change to N. If needed add ORM coverage/loss with ORM = Y.
70	ORM claim was entered with ORM indicator = no. Claim will not be sent to CMS until ORM indicator = yes or until TPOC date is entered.
71	No fault limit exceeds $99,999,999.99
72	Total of TPOC amounts exceed $99.999.999.99

Types of Claims to be Reported

Claim reporting for CMS is based on the claimant and the coverage. All liability, workers compensation medical (and related statutory insurance programs) and all medical payment-type coverages (referred to by CMS as No Fault claims), must be reported to CMS.

Reporting requirements to MMSEA Section 111 involve payment to a Medicare recipient of medical bills that apply to a claim for first party medical payments or Workers Compensation, and/or all liability bodily injury claims including or separately processed medical payments

See Appendix A for a chart showing which ISO Policy, Coverage and Loss types qualify for CMS reporting.

No-Fault Insurance and Workers' Compensation Claims (ORM Claims)

Examples of ORM claims are Auto no-fault or medical payments, premises medical payment and workers compensation medical.

A report for No Fault claimants must be reported with the acceptance of coverage or payment. Required fields of information must be reported in the quarterly file, but conditional required fields must be reported when known. Conditionally required fields are those that are required if the condition presents itself:

- Self insurance – if the risk is self insured vs. an insurance policy covers the risk for the claim involved.
- Representative (if known),

The ORM Indicator in ISO ClaimSearch is to be selected as "YES". Once this indicator is selected, it should remain for the life of the claim unless the claimant loses his/her medical recipient status.

Claimants with ORM will be reported at least twice to CMS. ISO will report the ORM claims to CMS based on the following rules:

- When there is a claim for medicals paid or accepted and your company submits a claim with a Medicare-eligible indicator set to "yes", ISO ClaimSearch will send the claim to CMS as an "add" record (Action Type "0").

- When your company changes a key field, ISO ClaimSearch will send the claim to CMS as a "delete" record (Action Type "1") followed by a new "add" record (Action Type "0"). Key fields include CMS Date of Incident, Plan Insurance Type and ORM Indicator.

- For claims already accepted by CMS, if you report the "Do not send to CMS" indicator at either the claimant or coverage level, remove the Medicare eligible indicator or change the indicator to "no", change the coverage to a non-CMS reportable type, or if the claim is voided from the ISO ClaimSearch database, ISO will send a "delete" record (Action Type "1") to CMS.

- When your company updates any fields that CMS designates as "important", ISO ClaimSearch will send the claim to CMS again as an update (Action Type "2"). Important fields include ICD-9 codes, TIN, TPOC Date, TPOC Amount, Additional Claimant Information, ORM Termination Date.

- When your company provides the ORM (ongoing responsibility for medicals) termination date, ISO ClaimSearch will send a final claim to CMS as an "update" record (Action Type "2"). The ORM termination date is when the responsibility for medical payments ends. **NOTE:** Termination

of Ongoing Medical responsibility is not necessarily when all medical has been paid. The termination date reflects the date when the company's duty to pay any medical claim by policy or statute ends. Future dates are accepted but should not be more than 6 months greater than the file submission date.

- **Single Payment Liability Claims (TPOC Claims)**

TPOC (total payment obligation to the claimant) claimants are only to be reported after the claim is settled through settlement, judgment or award. The TPOC indicator will include the date and amount of the settlement.

ISO will report the TPOC claims to CMS based on the following rule:

- When your company marks the claimant as Medicare eligible and provides the TPOC (total payment obligation to the claimant) date, ISO ClaimSearch will report the claim to CMS as an "add" (Action Type "0").
- ISO will send an update (Action Type "2") when additional TPOCs are added.

Claim Scenarios

- Reports to ISO ClaimSearch for CMS reporting are on the claimant and coverage level. The Medicare eligible indicator is on the person level. It is possible to have a claimant with a No Fault claim, such as a medical payments claim under a Homeowners Policy, and a Bodily Injury Liability claim in the same claim report. In these instances, the Medical Payments claim is an ORM claim, and the Liability claim is a TPOC claim.

Assuming the claimant is a Medicare recipient, the Medical Payments claim would be reported to CMS with the next quarterly file, to reflect the assumption of coverage or payment of a claim. The ORM indicator would be set to "Yes", but the ORM termination date may not be the date of the last medical, as the responsibility for payment of medicals is still active, per policy period. If the Homeowners policy carried a one year medical payments limitation, when that date was reached, the ORM termination date would be submitted.

The liability claim would not be reported to CMS until the claim was paid, through settlement, judgment or award. At the date the payment for settlement is made, the TPOC date and amount is entered. Once that information is entered in ISO ClaimSearch, a report is triggered to CMS on this claimant at the next quarterly reporting period. Note: The ORM Indicator continues to be set to "Yes".

- Mass Tort reporting: At this time, CMS has not advised the procedure under which a mass tort claim is to be reported. True Mass Tort claims involve many insurers, defendants, defense counsels, adjusters and claimants. The common thread is the cause of injury; related to a common injury or product, alleged to be defective, or the source of an occupational illness. Most of these cases are in litigation, with plaintiff counsel maintaining the list of plaintiffs. This list is usually unknown to the insurer until the mass tort is settled and the claim being paid or settlement certified under court order. At that time, the information involving the plaintiff's Medicare status can be developed. Issues involving which RRE reports the claimant is under advisement by CMS.

ISO has included a mass tort indicator and related litigation fields such as State of Venue, Location and Docket Number. State of Venue is the only CMS required field if the claim involves other state legislation.

It is currently a requirement for all insurers to report claimants who are Medicare recipients that either are paid medicals (ORM), or TPOC. If this applies to Mass Tort claims, all insurers that have been named in the action will be required to report to CMS once the settlement of these claims has been reached. **NOTE**: MMSEA, Section 111 does not include reporting of liability claims until settlement, judgment or award.

Other CMS reporting requirements are not discussed in this manual.

COMBINING NO-FAULT "PLAN D" COVERAGES

CMS has indicated that if more than one No-Fault "Plan D" coverage is reported, both coverages should be combined into one record when reported to CMS. Since many ISO ClaimSearch customers report multiple coverages, for example, you may report a PIP and Med Pay coverage for the same person, ISO will now combine those into one submission to CMS. To do so, ISO has developed the requirements below which will be used to combine multiple No-Fault coverages if they were reported separately to ISO ClaimSearch.

REQUIREMENTS FOR COMBINING CLAIMS FOR PLAN INSURANCE TYPE D

If more than one reported coverage maps to Plan Insurance Type D, we will combine the coverages and report one claim to CMS.

- If different dates of incident are reported, we will keep the earliest date.
- If there are different states of venue, we will keep the one that is reported with the date we used above. If there are multiple records with the same date but different states, we will take the first state reported for that date.
- All no fault insurance limits will be added together.
- For exhaust date, we will pick the latest date reported.
- For the ORM indicator, if at least one is "yes", we will send "yes". If all are "no", we will send "no".
- For the ORM Termination date, we will pick the latest date reported.
- For TPOC dates, amounts and funding delayed dates, we will send the first 5 reported.
- For ICD9 codes, we will send up to the first 19 unique ICD9s reported.
- For Cause of Injury, we will send the first one reported.

For Key Field Changes:

- If any date of incident is changed, we will find the earliest date. If the earliest date is the same as what was sent; do nothing. If different, send an update record.
- If any ORM indicator changes, if "yes" was originally reported, check to see if all are now "no". Only send an update if all changed to "no". If "no" was originally reported, check to see if any are now "yes" and only send an update if at least one is now "yes".
- Claim Type – if a claim type changes to a non-CMS type, we don't do anything unless the customer first sent a Delete from CMS transaction prior to changing the type.

Important Field Changes:

- If an ICD9 changes, we will send an update if any of the first 19 are different than what was sent before.
- TPOC Date, Amount & funding delayed dates, if any of the first 5 change, we will send an update.

Delete this Party/Coverage from CMS Indicator:

- If all records have the delete indicator, we will send a delete transaction.
- If the delete indicator is not on every coverage, we will send the delete transaction, but will then send a new Add record for any coverages that didn't contain the delete transaction.

Do Not Send this Coverage to CMS Indicator:

- If all records have this indicator, we will not send a transaction to CMS.
- If this indicator is not on every coverage, we will send an Add record for any coverages that didn't contain the indicator.
- If an add record was already sent to CMS and this indicator is later removed from a coverage that was not sent originally, we will send a combined record as an update to add this additional coverage information to the claim.

NOTE: On the Acknowledgement and Rejection file you will receive once your file has been processed, for any Plan D claim you reported, the coverage and loss type which will be displayed on the output file will be COMB/COMB. Currently, even if you only reported one No-Fault type coverage, the result file will still show COMB/COMB indicating that it was a "combinable" type. The original coverage and loss type reported will not be shown.

Thresholds

CMS has announced thresholds. If a claim falls below the threshold, it is not required to report the claim to CMS. The thresholds are listed below. ISO will provide a warning if the total of all TPOC amounts are below the current threshold. It is the company's responsibility to prevent sending a claim to CMS which falls below the threshold. If a claim is below the threshold and you do not want to send the claim to CMS, you can either not mark the Medicare-eligible indicator, or, if you do mark the indicator, you must also select the 'Do not send to CMS' indicator at the involved party level or the "Do not send this coverage to CMS" indicator at the coverage level in order to prevent your claim from being sent to CMS.

Ongoing Responsibility for Medicals (ORM): Workers' Compensation only

- Includes all medical payments coverage
- Reporting is required at first payment or acceptance of coverage and at termination of reporting responsibility
- Report any open ORM claim as of 1/1/10
- Threshold for WC medical claims is $750 with lost time less than 7 days

Total Payment Obligation to the Claimant (TPOC)

- Third party liability claims
- Report at closing: settlement, judgment or award or other payment
- Threshold; total payments:

TPOC AMOUNT Mandatory to be reported	TPOC Date Between	Minimum TPOC Amount	Required to be reported beginning
Over $100,000	10/1/11 – 3/31/12	$5000	1st Quarter 2012
Over $50,000	4/1/12 – 6/30/12	$5000	3rd Quarter 2012
Over $25,000	7/1/12 – 9/30/12	$5000	4th Quarter 2012
Over $5000	10/1/12 – 12/31/12	$5000	1st Quarter 2013
Over $2000	1/1/13 – 12/31/13	$2000	2nd Quarter 2013
Over $600	1/1/14 – 12/31/14	$600	2nd Quarter 2014
Over $0	1/1/15 – indefinite	$0	2nd Quarter 2015

- Reporting is required for all liability claims open as of 10/1/11
- "Look back period" is 12/5/1980 for open Liability and No-Fault claims. There is no look-back period for Workers' Compensation claims.

Please be advised that ISO does not look at the threshold dates or amounts when sending to CMS. If you have marked the Medicare-eligible indicator = yes and have entered a TPOC date, ISO will send your claim to CMS unless you mark the "Do not send to CMS" indicator.

Timing of Reporting

The timing of reporting the CMS required fields often depends on the type of reporting required. If the claimant has been identified as a Medicare eligible recipient and has submitted a liability claim to the insurer or self insurer, with no request for payment of medicals, the insurer or self insurer (and TPA) may not need to report the claimant to CMS until the claim has been settled.

It is important to know that the claimant is a Medicare recipient early in the process to determine if the CMS required fields must be completed. Remember, a claimant who is not a Medicare recipient at the outset of the claim may become eligible based on the seriousness of the injury, or other factors. It is because of this that ISO ClaimSearch will continue to query the claimant for eligibility until the claimant's status changes to Medicare eligible and the company activates the Medicare eligible indicator. See the Query section of this manual for more information.
Once the claimant is identified as a Medicare recipient, the fields of information required by CMS must be entered prior to the RRE's quarterly reporting period. If the settlement, judgment, award or other payment is within forty five (45) days prior to the start of the RRE reporting timeframe, then you may delay reporting until the next quarterly reporting period.

The company has the ability to add the Medicare eligible status to the claimant's report. The Medicare eligible indicator is the responsibility of the RRE (or organization charged with reporting on behalf of the RRE) to add to the ISO ClaimSearch report.

Even though it has been determined that the claimant is a Medicare recipient, occasionally the claim information to send to CMS has not yet been finalized; claimant SSN, or date of birth have not been obtained; a coverage question may exist, or the claim may not exceed the thresholds mentioned above. In these instances, a company can activate the 'Do not send this party to CMS' indicator or the 'Do not send this coverage to CMS' indicator to give the opportunity to obtain the required fields, determine if the claim exceeds the threshold, or the company has resolved any coverage issues. The claim will not be sent to CMS until the field is updated to reflect the company's intent to send the claim to CMS at the next reporting period.

NOTE: *It is incumbent upon the claims representative to update the 'Do not send this party to CMS' or the 'Do not send this coverage to CMS' indicator. ISO ClaimSearch will not remind the company that the indicator is active on the claim.*

Reporting Periods

ISO will build your quarterly claim file on the first day of your group reporting period. All claims to be included in that quarter's file must be entered into the ISO ClaimSearch system by midnight the day prior to the first day of your reporting window.

Below is a summary of the group reporting dates:

Group 1 January 1, April 1, July 1, October 1

Group 2 January 8, April 8, July 8, October 8

Group 3 January 15, April 15, July 15, October 15

Group 4 January 22, April 22, July 22, October 22

Group 5 February 1, May 1, August 1, November 1

Group 6 February 8, May 8, August 8, November 8

Group 7 February 15, May 15, August 15, November 15

Group 8 February 22, May 22, August 22, November 22

Group 9 March 1, June 1, September 1, December 1

Group 10 March 8, June 8, September 8, December 8

Group 11 March 15, June 15, September 15, December 15

Group 12 March 22, June 22, September 22, December 22

CLAIM REPORTING METHODS

Universal Format Requirement

All claims to be reported to CMS must be submitted to ISO ClaimSearch using the Universal Format reporting method. Only Universal Format includes the additional data elements required by CMS. The legacy formats do not contain the necessary data elements.

There are several methods that may be used to submit claims to ISO ClaimSearch via Universal Format. Customers may report claims via the ISO ClaimSearch website, or may develop a system-to-system interface in order to send a file directly from their claim system. A combination of methods may also be used. If your company currently reports to ISO ClaimSearch using a Universal Format automated feed, but you wish to supplement the information reported through that feed by updating the claims via the web, you will be able to pull up your previously reported Universal Format claims to add the additional necessary fields via the ISO ClaimSearch website. The information you add through the website will not be eliminated by a system Replacement report, but the information can be overwritten by a system Replacement. In other words, a system replacement will not blank out a field previously reported on the web, but a value reported through the web can be changed to a different value using a system replacement.

NOTE: XML Format is an alternate programming format that is the equivalent of Universal Format as the data elements and file processing are the same as Universal Format. References to Universal Format system-to-system reporting can be assumed to include XML Format unless specifically stated otherwise.

Web Reporting

As of July 17, 2009, the ISO ClaimSearch website Universal Format screens were updated to include the new fields of information required by CMS. If your company is familiar with reporting claims via the website, the new screens are very similar to the screens you are already familiar with. Some additional fields were added to existing screens, and a new screen was added for casualty claims. An asterisk (*) appears next to each field which is optional to ISO ClaimSearch reporting but is important for CMS reporting.

As of 1/1/2010, the legacy reporting screens are no longer supported for all customers. On that date, any web reporting company that had not already switched to Universal Format automatically began seeing the Universal Format screens for new claim submissions.

NOTE: *At this time, ISO has only discontinued legacy reporting for new claims entered via the ISO ClaimSearch website. Customers will still be able to send Initial legacy claims via system to system reporting until 12/31/11. Existing legacy companies can continue to send legacy system-to-system updates through 12/31/12 at which time system-to-system legacy reporting of new and existing claims will also be discontinued.*

System-to-System Reporting

For companies who report to ISO ClaimSearch using a Universal Format system-to-system interface (FTP or MQ), updated record layouts were provided in November, 2009 and were again updated in November, 2010. Customers using Universal Format to send to ClaimSearch via FTP or MQ should refer to the Universal Format Manual version 7.3.

Customers reporting via XML Format should refer to the XML Manual version 5.3 which was provided in March, 2011.

All changes for CMS reporting are summarized in the Summary of Changes section at the beginning of the manuals.

Some new fields were added to existing records/aggregates. Additional fields were added in new input records/aggregates. The new fields have also been added to the Echo records/aggregates on output. The new fields will not be displayed to other customers on match reports. In addition to the new input and

echo records/aggregates, a new record/aggregate was added to provide the warning messages for missing CMS required fields.

If your company needs the layouts, please contact the ISO ClaimSearch Database Development group at claimsearchdatabasedevelopment@iso.com.

Testing System-To-System Changes

If your company has an existing Universal Format system-to-system reporting method and is making programming changes to incorporate the new CMS fields, you may contact your designated ISO Testing Representative to arrange testing, or, if you don't know who your representative is, you may contact the ISO ClaimSearch Database Development group at claimsearchdatabasedevelopment@iso.com. Please note that prior to testing CMS functionality your company should complete the ISO Product Supplement and Authorization Forms in order to be set up in the ISO ClaimSearch membership system as CMS participants.

Updating System-to-System Claims via the Web

If your company currently reports to ISO ClaimSearch using a Universal Format automated feed, but you wish to supplement the information reported through that feed by updating the claims, you will be able to pull up your previously reported Universal Format claims to add the additional necessary fields via the ISO ClaimSearch website. The information you add through the website will not be eliminated by a system Replacement report, but the information can be overwritten by a system Replacement. See the ISO ClaimSearch Web User Manual for CMS Reporting version 2.0 for more information on updating claims via the ISO ClaimSearch website.

Converting Legacy Claims to Universal Format

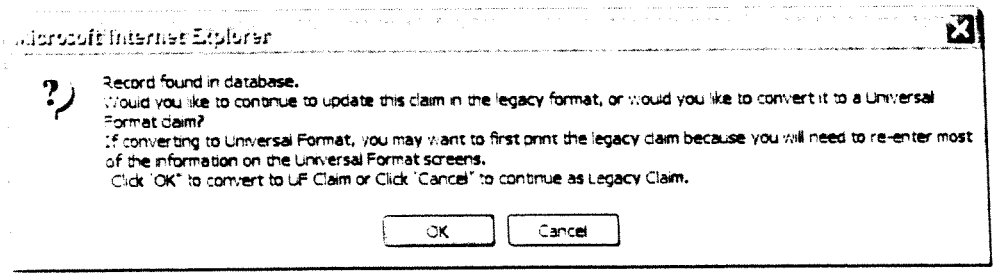
Companies that intend to have ISO ClaimSearch act as their Agent for CMS reporting must report to ISO ClaimSearch in Universal Format.

Companies that report their casualty claims in legacy format either through an automated feed or through the website must convert to Universal Format for CMS reporting. The ISO ClaimSearch Database Development group can assist companies in converting to Universal Format via a system-to-system method. You may contact them at claimsearchdatabasedevelopment@iso.com for more information. To convert to Universal Format reporting via the ClaimSearch website, please contact ISO Customer Service at (800) 888-4476.

ISO ClaimSearch participants that have already converted to Universal Format may still have historical legacy claims on the database. Those claimants may need to be reported to CMS if the claimant is a Medicare recipient.

System-to-system companies can convert legacy claims to Universal Format by submitting the claims as new Universal Format Initial claims with the Legacy Claim Conversion indicator set. All legacy claims that can be located in the ISO ClaimSearch system based on the key fields (customer code, claim number, policy number, date of loss and claimant name) will be deleted and replaced with a Universal Format claim. NOTE: All key fields must be identical to the original claim including the spelling of the claimant's name. Please refer to the "Transitioning from Legacy System Reporting" section of either the Universal Format Manual or the XML Manual for details regarding converting legacy claims to Universal Format through your automated feed.

Companies reporting via the ISO ClaimSearch website can now convert previously reported legacy claims to Universal Format. When the user retrieves a legacy claim, it will give the user the option to update the claim via the legacy format or to convert the claim to Universal Format. See below:



If the user chooses to convert to Universal Format, they will be brought to the Universal Format screens to re-enter the claim. It is important to note that you should print the legacy claim prior to choosing 'OK' so you will have the information needed to enter the data into the Universal Format screens. The legacy claim will be deleted upon submission of the new Universal Format claim. Please refer to the "Updating a Previously Reported Legacy Claim" section of the CMS Web User Guide version 2.0 for more information.

NOTE: *If your company uses a legacy system-to-system interface, the Supplements or Re-Indexes you submit for claims that have been converted to Universal Format will reject. Once a claim has been converted, you must submit changes to converted claims, such as Replacements and Researches, through Universal Format.*

NOTE: *For non-insurers who pay a transactional ISO ClaimSearch fee, please note that every time a claim is converted to Universal Format a new search is performed and thus a charge is generated, just as any time you replace a claim to add additional information, a search is performed and a charge is generated. The charge would be at the Universal Format rate which may not be the same fee as the legacy fee. (For pricing information, please contact your ISO ClaimSearch Account Executive). If a customer chooses to not have a search performed, they must check the 'Submit Claim Only – DO NOT Search' check-box at the bottom of the BASIC INFORMATION page on the web or the 'No Search Indicator' for system-to-system companies. If this indicator is sent, no ISO ClaimSearch match reports will be generated, and no CMS warning messages will be generated.*

ACKNOWLEDGEMENT AND REJECTION SERVICE OVERVIEW

Claims will be sent to CMS on a quarterly basis based on each RRE's assigned reporting period. Within 45 days, CMS will process the claims and will either accept or reject the claims. When ISO receives the results from CMS, ISO will convert the CMS results into separate acknowledgement and reject files per RRE and will post the results of that file on the Account Management section of the ISO ClaimSearch website. Authorized users can log in to download the files of accepted claims and/or rejected claims. Only users with access to this specific file will be able to log in. To obtain access for users, please complete the Authorization Forms provided in your ISO registration package. ISO will send an e-mail to the RRE's Account Manager informing them that the file has been posted.

ISO will link the acknowledgements and rejections to existing claim numbers, ISO file numbers and reporting codes in ISO ClaimSearch to help companies locate their claims in the database.

Users can update and resubmit the rejected claims to ISO ClaimSearch. The system will resubmit the claim to CMS during the next quarterly reporting period.

Below is what the Account Management screen looks like:

ISO ClaimSearch CMS Reports

Previous Page | Print

For reports questions, please call 201-469-3159, or send an e-mail to cmsreports@iso.com

RRE Code: 123456789 - Report Type: Errors and Ack.

Process

RRE # 123456789 - Description Of RRE Code

Acknowledgement Reports

Date	Excel File	TEXT File	Download
03/31/2009	Ack_123456789_03312009.csv	Ack_123456789_03312009.txt	
12/31/2008	Ack_123456789_12312008.csv	Ack_123456789_12312008.txt	
09/30/2008	Ack_123456789_09302008.csv	Ack_123456789_09302009.txt	Processing
06/30/2008	Ack_123456789_06302008.csv	Ack_123456789_06302008.txt	
03/31/2008	Ack_123456789_03312008.csv	Ack_123456789_03312008.txt	
12/31/2007	Ack_123456789_12312007.csv	Ack_123456789_12312007.txt	
09/30/2007	Ack_123456789_09302007.csv	Ack_123456789_09302007.txt	
06/30/2007	Ack_123456789_06302007.csv	Ack_123456789_06302007.txt	

Error Reports

Date	Excel File	TEXT File	Download
03/31/2009	Error_123456789_01312009.csv	Error_123456789_03312009.txt	
12/31/2008	Error_123456789_12312009.csv	Error_123456789_12312009.txt	
09/30/2008	Error_123456789_09302009.csv	Error_123456789_09302009.txt	
06/30/2008	Error_123456789_06302008.csv	Error_123456789_06302008.txt	
03/31/2008	Error_123456789_03312008.csv	Error_123456789_03312008.txt	
12/31/2007	Error_123456789_12312007.csv	Error_123456789_12312007.txt	
09/30/2007	Error_123456789_09302007.csv	Error_123456789_09302007.txt	

Users with access to download files for multiple RREs will see a drop down where they may select the RRE code for the file they wish to download. There will be a drop-down for a user to choose whether

they are selecting the quarterly Error and Acknowledgement files or the monthly Query Result Files. Customers may choose to download either the Excel File or the Text File.

When you click on the link, the files will be in a .zip file and when you extract the file, it will be either a .csv or .txt file.

Files will remain on the website for two years.

Below are the file names of the acknowledgement and rejection files that will be posted to the Account Management page of the ISO ClaimSearch website.

Acknowledgement

1. Zip file name (csv)– Ack_<RRECode>_<date (MMDDYYYY)>_csv.zip
2. CSV file name – Ack_<RRECode>_<date (MMDDYYYY)>.csv
3. Zip file name (txt)– Ack_<RRECode>_<date (MMDDYYYY)>_txt.zip
4. TXT file name - Ack_<RRECode>_<date (MMDDYYYY)>.txt

Examples:

Ack_999999999_10162009_csv.zip

Ack_999999999_10162009.csv

Ack_999999999_10162009_txt.zip

Ack_999999999_10162009.txt

Error

1. Zip file name (csv)– Error_<RRECode>_<date (MMDDYYYY)>_csv.zip
2. CSV file name – Error_<RRECode>_<date (MMDDYYYY)>.csv
3. Zip file name (txt)– Error_<RRECode>_<date (MMDDYYYY)>_txt.zip
4. TXT file name - Error_<RRECode>_<date (MMDDYYYY)>.txt

Examples:

Error_999999999_10162009_csv.zip

Error_999999999_10162009.csv

Error_999999999_10162009_txt.zip

Error_999999999_10162009.txt

NOTE: *Companies have asked if the file download process can be automated. Currently, an actual user must log into the site to download the file. ISO will consider a future enhancement to return the quarterly result files via FTP.*

The file will be posted in a text file format as well as an Excel format. See Appendix B for the layout of the quarterly result files.

Severe Errors/Threshold Errors

CMS has indicated that if an entire file contains a certain percentage of errors, the entire file will be suspended from processing. The RRE's Account Manager will be notified by CMS via e-mail. Please note that ISO will not be informed by CMS that your file has failed; only your Account Manager will be notified. It would be helpful if you would forward a copy of the e-mail regarding threshold errors to mspreporting@iso.com.

When you receive a threshold error, in most instances, we recommend that you contact your CMS EDI Representative and ask to have the file released for processing. This is the only way you will know exactly which claims rejected for which reasons. Once CMS releases the file, it will take up to 45 days for CMS to process the file. After the file has been processed, ISO will automatically retrieve the results and will post the Acknowledgment and Error file to the Account Management page of the ClaimSearch web site. At that time, you should make any corrections to rejected claims prior to your next quarterly reporting period.

ISO does not expect Severe Errors to occur, but if they do, you should contact ISO at MSPreporting@iso.com as well as your CMS assigned EDI Rep to resolve the situation. Severe errors occur if the file to CMS is not formatted properly or doesn't contain the required records or record counts.

Threshold errors may occur for several reasons. The most likely reason would be that more than 20% of your claims were in error, probably because of missing required fields or the file contained more than 5% delete records. If you receive threshold errors and your files are not processed, please contact ISO at MSPreporting@iso.com so we can work with you and your CMS assigned EDI Representative to determine the appropriate resolution. ***NOTE:*** *If your company does not want claims sent to CMS that you know are missing required fields, you can mark the 'Do not send this party to CMS' or 'Do not send this coverage to CMS' indicator until you obtain the fields necessary for reporting.*

Disposition and Compliance Codes

Below is a list of the disposition and compliance codes which will be returned by CMS. Claims with accepted disposition codes will be returned in the acknowledgement file and claims with rejected disposition codes will be returned in the error file.

DISPOSITION CODES

01 – Record Accepted for Individual Identified as a Medicare Beneficiary and ORM
ISO will return these claims in the acknowledgement file. For ORM claims, ISO will continually check to see if you've updated your claim with any important CMS fields and, if so, we will send updated records to CMS. We will send an update if you've added or changed the ICD9 Codes, TIN, TPOC dates, TPOC Amounts, Claimant 1 Information, or ORM Termination Date. If you've changed any key fields (injured party SSN, CMS Date of Incident, Plan Insurance Type, ORM

Indicator), ISO will automatically detect this and will send a DELETE record followed by a new ADD record. After your claims receive a disposition of "01," if you realize the claim was sent to CMS in error, you can send a "DELETE THIS PARTY FROM CMS" indicator.

02 – Record Accepted for Individual Identified as a Medicare Beneficiary and No ORM
ISO will return these claims in the acknowledgement file. ISO will continually check to see if you've updated your claim with any important CMS fields and, if so, we will send updated records to CMS. We will send an update if you've added or changed the ICD9 Codes, TIN, TPOC dates, TPOC Amounts, Claimant 1 Information. If you've changed any key fields (injured party SSN, CMS Date of Incident, Plan Insurance Type, ORM Indicator), ISO will automatically detect this and will send a DELETE transaction followed by a new ADD record. After your claims receive a disposition of "02," if you realize the claim was sent to CMS in error, you can send a "DELETE THIS PARTY FROM CMS" indicator.

SP – Record in Error
ISO will return these claims on the error file. *ACTION ITEM:* You must make the necessary corrections to your claim by sending an update or replacement to ISO ClaimSearch. When you do so, make sure you don't receive any Warning messages on your match report. A Warning message will not stop us from trying to send your claim to CMS again. ISO will recognize that you made a change to your claim and will try to re-send it in the next quarterly reporting period. We don't check to see what you've changed; only that you've updated/replaced your claim, so if you didn't make any/all of the necessary corrections, the claim will fail again.

51 – Injured Party Not Identified as a Medicare Beneficiary
These aren't truly errors because they don't count toward the 20% error threshold; however, ISO will return these claims on the error file because action is required by you. *ACTION ITEM:* You should update or replace the claim to remove the Medicare eligible indicator = YES. ISO will then begin to query these claims for you again to alert you know if the person becomes eligible in the future. If you learned that the person was eligible through the query process and properly updated the claimant in the database, there is no reason you should receive this error.
*** NOTE: CMS used different criteria prior to November 2010 to determine eligibility than they are using now. It is possible that a query file prior to November 2010 may have indicated that a person is Medicare eligible, but now a Disposition 51 is being returned saying that the person is not eligible. In this instance, CMS recommends beginning the query process again. To do so, remove the Medicare eligible indicator from the claim. ***

03 – Record Accepted for Individual Identified as a Medicare Beneficiary but Outside Medicare Coverage Period
ISO will return these claims on the acknowledgement file. Although CMS says that it "accepted" these records, the records are not actually being saved in its system. These are claims where the injured party is a beneficiary, but the Medicare coverage dates are outside the time period between the date of incident and TPOC or ORM Termination date. If you have ORM for these claims, you must continue to monitor the status of the injury. For ORM claims, ISO will continue to submit new ADD records on subsequent quarterly claim input files until we no longer receive an "03" disposition or until the ORM Termination Date is reported.

50 – The COBC did not finish processing the record in time to produce a response record within the 45-day turnaround.

This should happen only in rare circumstances. ISO will return these in the error file. You do not need to do anything. ISO will automatically re-submit your claim during the next quarterly reporting period.

ERROR CODE

SP31 – Record submitted prior to effective date of Medicare entitlement.
You do not need to do anything. ISO will automatically re-submit your claim during the next quarterly reporting period.

SP32 – Miscellaneous error.
You do not need to do anything. ISO will automatically re-submit your claim during the next quarterly reporting period.

SP50 – Record is locked by the COBC.
You do not need to do anything. CMS does not want any resubmissions of this record. ISO will not resubmit this record or any changes to this claim to CMS.

TN99 – TIN/Office Code error
ISO will monitor the TIN Reference Response File and will contact you if the errors cannot be corrected by ISO.

COMPLIANCE CODES

Compliance Codes 01 & 03
These compliance codes inform you of late submissions. No action needs to be taken.

Compliance Code 02
This compliance code is sent if the TIN in the TIN Reference File couldn't be validated by the COBC. If you receive this code, please contact ISO since ISO builds the TIN Reference File for you. You may not have provided ISO with the correct TIN to use for your company.
NOTE: *This code is obsolete after 10/1/11.*

Compliance Codes 04 through 09
These compliance codes are sent when invalid TIN/Office Code Addresses are sent on the TIN Reference File Detail Record. Codes are provided for invalid Mailing Address Line 1 (code 04), invalid Mailing Address Line 2 (code 05), Invalid City (Code 06), Invalid State (Code 07), Invalid Zip Code (08) and Invalid Foreign Address (Code 09). See the CMS ALERT: TIN Reference File Address Validation Information dated November 18, 2010 for more information.
NOTE: *These codes are obsolete after 10/1/11.*

TIN REFERENCE RESPONSE FILE

As noted in an Alert posted by CMS dated 4/1/11, effective October 1, 2011, CMS will begin posting a new TIN Reference Response File for every TIN Reference File submitted. CMS will begin editing the addresses associated with your SITE IDs using postal software to ensure that an address is actually deliverable. If any of the addresses do not pass CMS' validation, an error code will be returned in this new file.

ISO currently sends a TIN reference file with every quarterly file submitted on your behalf. In order to save you work time, ISO plans to retrieve these new files and internally monitor the files for errors. You will not be required to make changes to retrieve or react to the additional files. If any of the addresses associated with your SITE IDs reject, you will receive Error Code TN99 in your current CMS Rejection file on the Account Management page of the ISO ClaimSearch website; you do not need to do anything with these errors. The detailed error code will be sent in the new TIN Reference Response File, which ISO will retrieve and monitor. ISO will attempt to diagnose the problem and will contact you if changes need to be made to the addresses you selected to be associated with your SITE IDs in ISO's membership database. ISO will then re-submit a corrected TIN reference file to CMS on your behalf.

No changes to your set up should be required for you to meet the new CMS requirements. ISO will monitor any problems related to invalid SITE ID addresses on TIN Reference Files and will contact your Account Manager if changes are needed.

ISO ClaimSearch MSP Account Management

ISO developed management reports to assist companies in verifying the accuracy of the data provided to ClaimSearch for Medicare Secondary Payer reporting. These management reports will help ensure that the proper individuals are identified as Medicare recipients, that the required data elements are populated on the claims and the proper of volume of claims are reported to CMS.

The reports are accessible on the Account Management page of the ClaimSearch website under CMS Section 111 Management Reports for users who have been designated with access. If you have additional users requiring access, please contact njsupport@iso.com.

Medicare Eligible Report

This report identifies all the claimants that the company has marked as "Medicare eligible" within ClaimSearch for a given month. This report ensures that systems are transmitting the required data in order for claimants to be identified as Medicare recipients and/or that users are updating the claims on the ClaimSearch website with the "Medicare eligible" indicator. Below is a screenshot of the report:

ISO Claimsearch CMS Medicare Eligible Claimants Report

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For questions on the reports, please call 800-888-4476, or send an e-mail to Claimsearchmsp@iso.com

RRE Code: 711111111 **For:** Dec 2010 **Report Type:** Medicare Eligible Claimants

RRE # 711111111 - 1 2 >>

Office Code	Claim Number	Policy Number	Date Of Loss	Claimant Name
Z99500001	1234	1234	10/25/2010	MACK,MARY
Z99500001	121212	121212	11/17/2010	PAYKIN,BORIS

The report provides an RRE Code drop-down if you have access to view the report for more than one RRE.

The first report available dated November 2010 is a cumulative report containing all claimants who were marked as Medicare eligible = yes through the end of November. Each report thereafter only contains the claims that were marked as Medicare eligible that month.

Please note that all claimants on this list will NOT automatically be reported to CMS. The claims will not be sent to CMS if you have marked the indicator on a type of claim or party who is not reportable to CMS, or if you have marked the "Do Not Send to CMS" indicator, or if it is a TPOC claim and the TPOC date has not been provided yet.

Active Warnings Report:

This report will provide users with access to any claims that contain the ISO ClaimSearch CMS Warnings. This is a live report and is generated at the time it is requested. For this reason, it may take a few minutes for the report to be generated. This report will give RREs the ability to see for which claimants they have marked as Medicare eligible, but have missing CMS required fields in order for the companies to update claims to ensure they won't reject from CMS. Below are screenshots of the report:

ISO Claimsearch CMS Active Warning Report

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For questions on the reports, please call 800-888-4476, or send an e-mail to Claimsearchmsp@iso.com

RRE Code: 744444444 **Report Type:** Active Warning

RRE # 744444444 -

Office Code	Claim Number	Policy Number	Date Of Loss	Claimant Name	Details
Z99500001	TEST3	TEST3	06/18/2010	GWSGFLDFJ,EFJLSKDFJSKLD	View
Z99500001	TESTCLM89	TESTCLM89	12/12/2008	CCB,CVBCVBCVB	View
Z99500001	TESTCLM89	TESTCLM89	12/12/2008	BCVB,CVBCVB	View
Z99500001	TEST1	TEST1	06/18/2010	WEUWEO,RGJERJGOPRGT	View
Z99500001	TEST4	TEST4	06/18/2010	EFKLJSDLFKJ,LFJLSKFJSKLJ	View
Z99500001	TEST5	TEST5	06/18/2010	TRETER,TYQREWER	View
Z99500001	TEST2	TEST2	06/18/2010	TRWETWET,ERTYRTWE	View

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The report provides an RRE Code drop-down if you have access to view the report for more than one RRE.

To see the details showing which warnings exist on each claim, click on "View" and you will see this screen. Each claim can have multiple warnings.

CMS Warning Detail Report

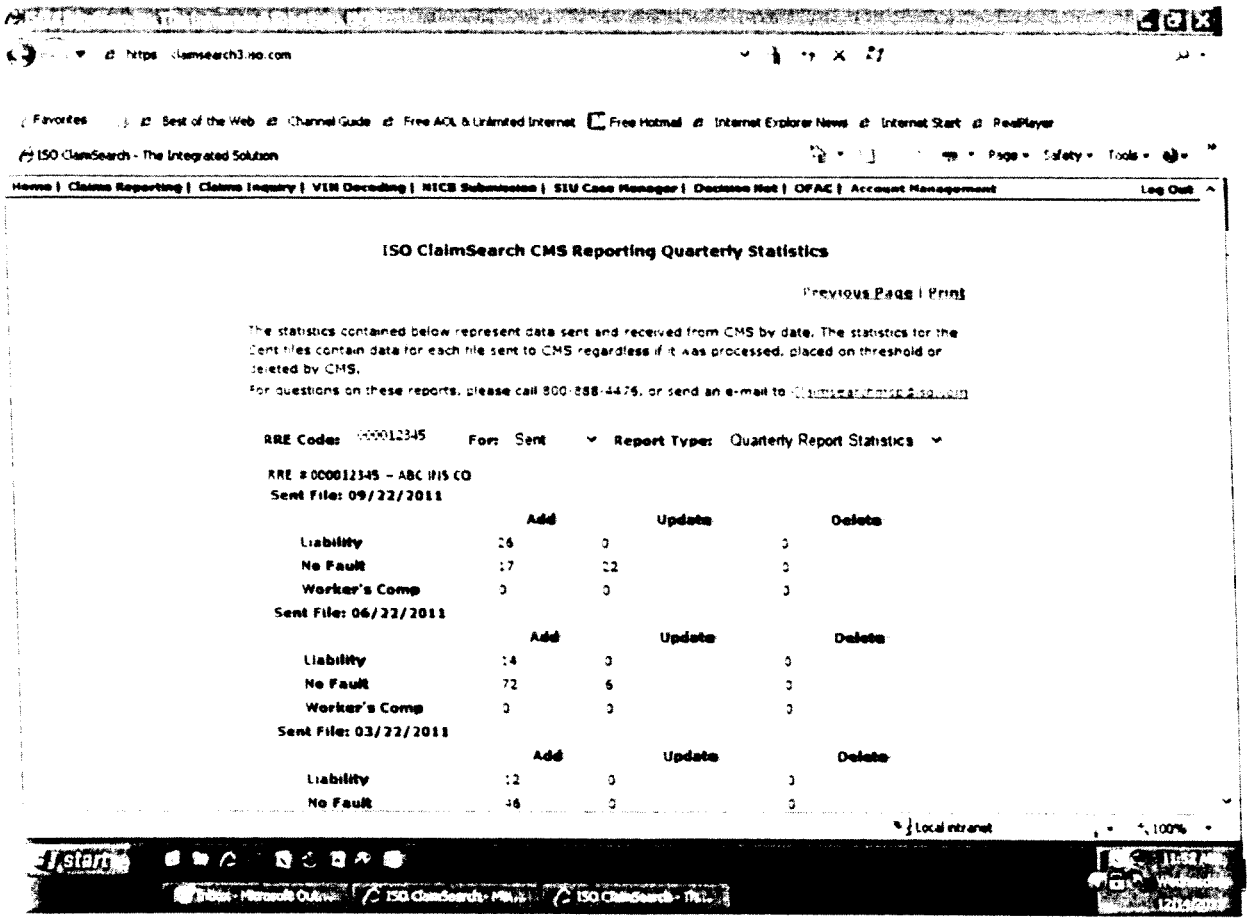
RRE Code	Office Code	Claim Number	Policy Number	Date of Loss
[illegible]	23950001	TEST2	TEST2	06 18 2010

	Claimant Name	Coverage Type	Loss Type	Do Not Send To CMS	Active Warning
1	[illegible]	MPAY	BODI		Date of Incident Missing or Invalid
2	[illegible]	MPAY	BODI		Injured Party DOB missing or Invalid
3	[illegible]	MPAY	BODI		Injured Party HICN or Injured party SSN is required
4	[illegible]	MPAY	BODI		No-Fault Insurance Limit Missing or Invalid
5	[illegible]	MPAY	BODI		ORM Indicator Missing or Invalid
6	[illegible]	MPAY	BODI		State of Venue Missing or Invalid

Print| Close

Quarterly Reporting Statistics

The Quarterly Reporting Statistics report will enable users to verify that the correct volume of claims are reported to CMS on a quarterly basis. The report is broken down by CMS Plan Type (Liability, No Fault and Workers' Compensation. When the quarterly files are returned, users can view the volume accepted and rejected from CMS. Below is a screenshot of the "Sent File" portion of this report. It will be created quarterly after the quarterly file is sent to CMS.



ISO ClaimSearch CMS Reporting Quarterly Statistics

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The statistics contained below represent data sent and received from CMS by date. The statistics for the Sent files contain data for each file sent to CMS regardless if it was processed, placed on threshold or deleted by CMS.

For questions on these reports, please call 800-888-4476, or send an e-mail to [illegible]

RRE Code: 000012345 For: Sent Report Type: Quarterly Report Statistics

RRE # 000012345 - ABC INS CO

Sent File: 09/22/2011

	Add	Update	Delete
Liability	26	0	0
No Fault	17	22	0
Worker's Comp	0	0	0

Sent File: 06/22/2011

	Add	Update	Delete
Liability	14	0	0
No Fault	72	6	0
Worker's Comp	0	0	0

Sent File: 03/22/2011

	Add	Update	Delete
Liability	12	0	0
No Fault	46	0	0

Below is the "Received File" portion of this report. It will remain blank until CMS processes the file and provides the results.

ClaimSearch

Account Management

Home | Claims Reporting | Claims Inquiry | VIN Decoding | NICB Submission | SIU Case Manager | Decision Net | OFAC | Account Management | Log Out

ISO ClaimSearch CMS Reporting Quarterly Statistics

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The statistics contained below represent data sent and received from CMS by date. The statistics for the Sent files contain data for each file sent to CMS regardless if it was processed, placed on threshold or deleted by CMS.

For questions on these reports, please call 800-888-4476, or send an e-mail to [illegible]

RRE Code: 000012345 **For:** Received **Report Type:** Quarterly Report Statistics

RRE # 000012345 – ABC INS CO

Received File: 10/25/2011

	Accepted			Rejected
	Add	Update	Delete	
Liability	0	0	0	4
No Fault	0	0	0	0
Worker's Comp	0	0	0	0

Received File: 10/12/2011

	Accepted			Rejected
	Add	Update	Delete	
Liability	10	0	4	17
No Fault	13	22	0	4
Worker's Comp	0	0	0	0

Received File: 06/28/2011

	Accepted			Rejected
	Add	Update	Delete	
Liability	12	0	0	2
No Fault	61	5	0	12
Worker's Comp	0	0	0	0

Received File: 03/30/2011

start | Inbox - Microsoft Outlook | ISO ClaimSearch - Mic... | ISO ClaimSearch - Th...

PRIVACY AND SECURITY

ISO ClaimSearch operates in accordance with state and federal privacy legislation. The Gramm-Leach-Bliley Act of 1999 (P.L. 106-102), 15 U.S.C., Section 6801 *et sec.*, and the National Association of Insurance Commissioners' Privacy of Consumer Financial and Health Information Model Regulation ("NAIC Model Rule") and its Insurance Information and Privacy Protection Model Act ("NAIC Model Act") permit the use of the ISO ClaimSearch database for fraud fighting and claims administration purposes.

Please refer to the ISO ClaimSearch and Security Policy for additional information.

Disclosure of Medicare Secondary Payer Information

ISO ClaimSearch participants are authorized to participate in and share personally identifiable information (PII), for the adjustment of claims or the investigation of fraud. ISO ClaimSearch is sensitive to the sharing of possible protected health information (PHI) by non-covered entities. Although ISO's position is that the majority of ISO ClaimSearch data is not considered PHI, ISO will not release data in fields of information added to ISO ClaimSearch specifically for compliance with Medicare Secondary Payer requirements to any party other than the company that enters the information. Data in fields added for Medicare Secondary Payer requirements will not appear in match reports to other ISO ClaimSearch participants. ISO ClaimSearch participants are to use considerable discretion in the disclosure of information filed on ISO ClaimSearch reports, especially in those CMS designated fields returned to the originating reporting organization, both as direct ISO ClaimSearch participants, or third party administrators reporting on behalf of ISO ClaimSearch participants.

TRAINING

ISO has posted documentation and recorded Web-Ex training sessions to the ISO website at www.iso.com/msp as well as to the User Manuals and Guides section on the ClaimSearch website at https://claimsearch.iso.com for users with access. See the AVAILABLE RESOURCES section of this guide for more information. ISO also offers individual company training. If your company is interested in online or in person training (some minimum attendance is required), please contact ISO ClaimSearch Customer Service at (800) 888-4476.

TESTING WITH CMS

ISO completed "pilot testing" with the Coordination of Benefits Contractor (COBC). By completing the pilot, the COBC will automatically move the RREs from Testing Status to Production Status. *If your RRE is currently listed in "testing" status, please contact your CMS EDI Representative and ask to be switched to "production" status.* There is no further testing an RRE is required to perform in order to be in Production Status. If an RRE wishes to conduct further testing on an individual basis, ISO can accommodate this request. Please email ClaimSearchMSP@iso.com with your request.

APPEND-DS

To help your company obtain Social Security numbers for claimants, ISO offers an optional service, Append-DS (Append Data and Search). Append-DS will trigger a public-records search when companies report a claim without an SSN.

The system will:

- retrieve public-records information on the claimant, including Social Security Number (SSN)
- telephone number, age, date of birth, and up to four previous addresses
- search the ISO ClaimSearch database for any matching claims using the SSN
- append the SSN and other new information retrieved from public records to the outgoing ISO ClaimSearch match report

Companies can add the SSN and other public records information to the claim report in the database by filing a replacement report. ISO ClaimSearch will not add the information automatically to the claim, store it in the database, or send it to CMS. It is the participating company's responsibility to update the original claim with any pertinent information retrieved through this service.

Append-DS is available at an additional charge. If you are interested in learning more about this service, please contact us at claimsearch.sales@iso.com.

AVAILABLE RESOURCES

Resources on ISO Website

The following resources are available on the MSP page of the ISO website at www.iso.com/msp:

Technical Information

- Instructions and Resources for Medicare Secondary Payer Reporting Service (PDF)
- View the CMS flow for third-party liability claims (PDF)
- View the CMS flow for PIP, MPAY, and WC Med-only claims (PDF)
- CMS Required Field Warnings Generated by ISO ClaimSearch

General Information

- Deadlines for Medicare Secondary Payer Reporting Service
- View the FAQ about the service (PDF)
- Read our comprehensive overview of the service (6/2/09) (PDF)

Web Seminars

- View a recorded web seminar about the ISO ClaimSearch Medicare Secondary Payer Reporting Service (11/09/09)
- View a PDF of the recorded web seminar about the ISO ClaimSearch Medicare Secondary Payer Reporting service (11/09/09)
- View a slide show on the CMS reporting registration process (6/2/09) (PDF)
- View a PDF of the web seminar (6/9/09) (PDF)
- Listen to a recorded web seminar on MMSEA reporting requirements (9/29/09)

Teleconferences

- April 29

E-mail Blasts and Mailings from ISO

- ICD-9 and External Cause of Injury Codes (11/12/10)
- CMS Alert: Changes to the Timeline for Reporting TPOC Claims (11/9/10)
- Registration, Pre-Query, Updates and Resources (3/12/10)
- Registration, Pre-Query, Updates and Resources (8/18/09)
- Convert legacy claims to Universal Format on the ISO ClaimSearch website (7/15/09)
- Enhanced Universal Format web screens (7/10/09)
- View the registration letter for ISO ClaimSearch casualty participants (6/2/09) (PDF)

Information from the Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS)

- View the CMS website

Resources on ISO ClaimSearch Website

The following information is available on the ISO ClaimSearch website at https://claimsearch.iso.com. Users with IDs can access the information below on the User Manuals & Guides section.

FAQ

ISO ClaimSearch Medicare Secondary Payer Reporting Service FAQ

Testing New CMS Fields

Letter - Companies Testing New CMS Fields
XML manual - version 5.3
Universal Format manual - version 7.3

Layouts for File Returns from CMS

Letter sent with Query Response File Layout, Acknowledgement File Layout, Error File Layout

Training Webinars

Tuesday, June 14, 2011 ISO ClaimSearch MSP Webinar Recording - CMS Webinar Session – ORM and TPOC reporting mapping in ClaimSearch

Tuesday, June 07, 2011 ISO ClaimSearch MSP Webinar Recording - CMS Webinar Session – CMS & ISO Registration Overview

Thursday, June 1, 2011 ISO ClaimSearch MSP Webinar Recording - CMS Webinar Session - Required Field Warning Codes

Tuesday, May 24, 2011 ISO ClaimSearch MSP Webinar Recording - Obtaining Key CMS Data Elements using Append-DS

May 17, 2011 ISO ClaimSeach MSP Webinar Recording - Reviewing and Understanding our CMS Management Reports

May 12, 2011 ISO ClaimSearch MSP Webinar Recording - Reporting ICD-9/Cause of Injury Codes

December 16 ISO ClaimSearch Medicare Secondary Payer Reporting Service User Meeting Webinar Recording

November 24 ISO ClaimSearch Medicare Secondary Payer Reporting Service Training Webinar Recording

July 15 ISO ClaimSearch Medicare Secondary Payer Reporting Service Webinar Recording

July 15 ISO ClaimSearch Medicare Secondary Payer Reporting Service Webinar Recording

July 15 ISO ClaimSearch Medicare Secondary Payer Reporting Service Webinar PowerPoint Presentation

Pre-Query Extract File Information and Layouts

Pre-Query Extract File Information and Layouts

ISO ClaimSearch Medicare Secondary Payer Reporting Service Web Manual

ISO ClaimSearch Medicare Secondary Payer Reporting Service Web Manual

ISO ClaimSearch Medicare Secondary Payer Reporting Service User Guide

ISO ClaimSearch Medicare Secondary Payer Reporting Service User Guide

CMS Disposition and Compliance Codes

CMS Disposition and Compliance Codes

CMS ICD-9 and Cause of Injury Code Lists

ISO provides the codes that have been published by the **World Health Organization (WHO)** and provided by **The Centers for Medicare & Medicaid Services (CMS)** for use with Medicare Secondary Payer Reporting. For your convenience, ISO ClaimSearch has combined all applicable versions from the CMS website into two excel worksheets.

Please Note: CMS requires at least one ICD-9 Diagnosis code and Cause of Injury code for new records submitted on or after 1/1/11. CMS will review the accuracy of ICD-9 codes to injuries provided, so please be sure to verify your selection(s).

CMS ICD-9 Code List
CMS Cause of Injury Code List

Resources Available Through Your ISO Account Executive

- Product Supplement
- Authorization Forms
- Pre-Query Extract Forms
- Information on Append-DS

Contact us at claimsearchsales@iso.com.

Resources Available Through CMS

http://www.cms.hhs.gov/MandatoryInsRep/

WHO TO CONTACT

For more information, e-mail the ISO ClaimSearch Electronic Reporting Office at claimsearchmsp@iso.com or call 1-800-888-4476.

APPENDIX A – CLAIM TYPES FOR QUERY AND REPORTING TO CMS

Policy, Coverage and Loss Determinations in Universal Format for Medicare Secondary Payer Section 111 Reporting

Medicare Secondary Payer Section 111 reporting specifies three types of (plans) coverage:

- No Fault - defined as any policy coverage or self insured retention that responds to payment for medicals. It is not limited to Automobile coverages under PIP or Med Pay, but also premises medical payments coverage under Commercial and Personal package policies. Terminology adopted that responds for medical payments covered is "Ongoing Responsibility for Medicals (ORM).

- Liability - defined as any policy, or risk retention program, that responds to legal or contractual responsibility for an injury caused to a third party, resulting in a settlement, judgment or award. Terminology adopted for these claims is "Total Payment Obligation to the Claimant" (TPOC).

- Workers Compensation - defined as a regulated program by Federal or State legislation to respond for medical payments and indemnification of claimants hurt while in the course and scope of their employment. Terminology adopted by CMS to respond to these claims is either ORM or TPOC (in the event of a settlement), subject to conditions, thresholds and procedures found in the Medicare Secondary Payer Section 111 User Guide (various editions), produced by CMS,

ISO ClaimSearch utilizes the ISO ClaimSearch Universal Format reporting program wherever possible. As participants are required to select policy, coverage and loss for all claims submitted to ClaimSearch, we try to use the same ISO procedures to reduce redundancy and increase efficiency in reporting.

The Appendix A Policy, Coverage and Loss types for CMS reporting follows the same process as reporting to ClaimSearch in Universal Format. We have, based on the claim type selected, identified the report type (ORM or TPOC) through mapping the policy, coverage and loss as submitted. There is no need for you to identify these types independently since ISO derives the type for you.

As a general rule, claims associated with third party bodily injury claims are considered TPOC claims. Medical Payments under PIP, Med Pay or Workers Compensation are considered ORM for CMS reporting purposes. Currently, ISO is handling all WC claims as ORM. ISO ClaimSearch provides the ability to submit TPOC information on a WC settlement, if companies intend to report Workers Compensation settlements in this manner. Any TPOC information entered on a WC claim will be sent to CMS at the designated ORM timeframes.

We have identified the applicable policy, coverage and loss types that are required for CMS Section 111 reporting. We have also identified and explained policy, coverage and loss types that may cause some confusion in their relative definitions. Types requiring further definitions are marked in the chart below with an asterisk (*) and the definition is explained in the Comments column.

NOTE: The ISO ClaimSearch Policy, Coverage and Loss tables are designed to align claims with associated coverage types to assist in the identification of the losses against those submitted by participating companies in match report review. These codes may not include all policy, coverage and loss types, but will include those to respond for CMS Section 111 reporting through ISO ClaimSearch.

On the next page are the Universal Format System-to-System Policy/Coverage/Loss Types, Web Policy/Coverage/Loss Types and Legacy Claim Types which qualify for the Query and Reporting to CMS. Note: Legacy reporting may be used for the CMS query process to identify claimant Medicare eligibility but will not be accepted for reporting to CMS Section 111. Universal Format is required for Section 111 reporting.

Often more than one coverage and loss type will be appropriate for reporting to ISO ClaimSearch and CMS Section 111 reporting. These coverages may represent both a Liability claim (TPOC) and a Medical Payments claim (ORM) in the same loss under the same policy. Separate coverages are to be submitted in the event there are both TPOC and ORM claims in the same report.

Universal Format

Commercial Policies						
Policy	**Coverage**	**Loss Type**	**Comments**	**Ongoing Medical (No Fault) (ORM)**	**Liability (TPOC)**	**WC**
CPMP (*) COMMERCIAL MULTI PERIL	**PINJ (*)** (PERSONAL INJURY)	**BODI** (BODILY INJURY)	**(*) CPMP** - Commercial Package policy; includes first and third party coverage. **(*)PINJ** – Personal Injury; not to be confused with Bodily Injury. Includes libel, slander, discrimination , wrongful termination, etc...		X	
		OTCA (OTHER CASUALTY)	(*) OTCA should be entered for other casualty bodily injury claims		X	
		OTPI (*) (OTHER PERSONAL INJURY)	**(*) OTPI** - Personal injury other than bodily injury loss type (may be no bodily injury allegations)		X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
CPMP (*) (continued)		**ENVR** (ENVIRONMENTAL)	Should include only injury claims		X	
		OTCA (OTHER)			X	
	PROD (*) (PRODUCTS & COMPLETED OPERATIONS)	**BODI** (BODILY INJURY)	**(*)PROD –** Product Liability and Completed Operations; coverage can be BODI or Other loss type. Report injury only for CMS.		X	
		OTCA (OTHER)			X	
	PTCI (*) (PROTECTION & INDEMNITY)	**BODI** (BODILY INURY)	**(*)PTCI –** Protection and Indemnity; coverage provided for Marine exposures.		X	
		OTCA (OTHER)			X	
	DRCT (DIRECTORS & OFFICERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	EROM (ERRORS & OMISSIONS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	ERPL (EMPLOYERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)				
	LIAB (*) (LIABILITY)	**BODI (BODILY INJURY)**	(*)LIAB – Liability; third party coverage; bodily or personal injury for CMS reporting.		X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
CPMP (*) (continued)		**DOGB** (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		BISF (SLIP & FALL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	MPAY (*) (MEDICAL PAYMENTS)	**MPAY** (MEDICAL PAYMENTS)	**(*)MPAY –** Medical Payments; medical payments coverage included in package policies (non-auto).	X		
		BODI (BODILY INJURY)		X		
	OTLB (*) (OTHER LIABILITY)	**BISF** (SLIP & FALL)	**(*)OTLB –** Other Liability; other liability coverage for injury not included above.		X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (*) (MEDICAL PAYMENTS)	(*) MPAY can include medical payments as a basis for liability payment vs. a coverage afforded under the policy.	X		

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
CFRM (FARMOWNERS)	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
CCGL (GENERAL LIABILITY)	**DRCT** (DIRECTORS & OFFICERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	EROM (ERRORS & OMISSIONS)	**BODI (BODILY INJURY)**			X	
		OTCA (OTHER)			X	
	ERPL (EMPLOYERS)	**BODI (BODILY INJURY)**			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
CCGL (continued)		**OTCA** (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	LIAB (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	(*)POLL (POLLUTION)	**BODI** (BODILY INJURY)	(*) should include only injury claims		X	
		ENVR (ENVIRONMENTAL)			X	
		OTCA (OTHER)			X	
	MED PAY	**MPAY** (MEDICAL PAYMENTS)		X		
		BODI (BODILY INJURY		X		

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
	PROD (PRODUCTS & COMPLETED)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
PLIB (PROFESSIONAL LIABILITY)	**DRCT** (DIRECTORS & OFFICERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	EROM (ERRORS & OMMISIONS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	ERPL (EMPLOYERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	LIAB (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTPI (OTHER PERSONAL INJURY			X	
		OTCA (OTHER)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI (BODILY INJURY)**		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF (SLIP & FALL)**			X	
		BODI (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
PLIB (continued)		**DOGB** (DOG BITE)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
MMAL (*) (MEDICAL MALPRACTICE)	**OTLB** (OTHER LIABILITY)	**BISF** (SLIP & FALL)	**(*)MMAL** – Medical Malpractice; Liability claims under Med Mal policies.		X	
		BODI (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		MPAY (MEDICAL PAYMENT		X		
COMR (*) (OCEAN MARINE)	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)	**(*)COMR** – Commercial Ocean Marine; Commercial Marine policies; includes all liability coverages for CMS reporting.		X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER CASUALTY)			X	
	PTCI (PROTECTION & INDEMNITY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER CASUALTY)			X	
OLIB (*) (OTHER LIABILITY)	**DRCT** (DIRECTORS & OFFICERS)	**BODI** (BODILY INJURY)	**(*)OLIB –** Other Liability; can include liability coverages other than BODI for CMS reporting.		X	
		OTCA (OTHER)			X	
	EROM (ERRORS & OMISSIONS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	ERPL (EMPLOYERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	LIAB (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
		OTCA (OTHER)			X	
	PINJ (PERSONAL INJURY)	**OTPI (OTHER PERSONAL INJURY)**			X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	
		ENVR (ENVIRONMENTAL)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		OTCA (OTHER)			X	
	PROD (PRODUCTS & COMPLETED)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
UMBR (*) (UMBRELLA)	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)	**(*)UMBR** – Umbrella Coverage; specific excess and drop down liability coverage. Report injury only for CMS.		X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER CASUALTY)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER CASUALTY)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
CAVN (COMMERCIAL AVIATION)	LIAB (LIABILITY)	**BISF (SLIP & FALL)**			X	
		BODI (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
CAVN (continued)		**DOGB** (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
CLBO (COMMERCIAL BUSINESS OWNERS)	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	
		ENVR (ENVIRONMENTAL)			X	
		OTCA (OTHER)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
CAPP (*) (COMMERCIAL AUTO)	**BODI** (BODILY INJURY)	**BODI** (BODILY INJURY)	**(*)CAPP** – Commercial Auto Policy; policies written on commercial vehicles or personal vehicles used for business purposes; first party or third party.		X	
		MPAY (MEDICAL PAYMENTS)		X		
		NFLT (PIP)		X		
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	
	GGKP (GARAGE-KEEPERS)	**BODI** (BODILY INJURY)			X	
		OTAU (OTHER AUTO)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** **(BODILY INJURY)**		X		

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		MPAY (MEDICAL PAYMENTS)		X		
		OTAU (OTHER AUTO)		X		
		TRSM (TERRORISM)		X		
	NFLT (PIP)	**NFLT** (PIP)		X		
		OTAU (OTHER AUTO)		X		
		BODI (BODILY INJURY)		X		
	OTAU (*) (OTHER AUTO)	**BODI** (BODILY INJURY)	**(*)OTAU –** Other Auto; can be used for non-owned auto coverage, or any Auto coverage not included in other coverage types.		X	
		MPAY (MEDICAL PAYMENTS)		X		
		NFLT (PIP)		X		
		OTAU (OTHER)			X	
		TRSM (TERRORISM)			X	
	UNDR (UNDER-INSURED MOTORIST)	**BODI** (BODILY INJURY)			X	
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	
	UNIN (UNINSURED MOTORIST)	**BODI** (BODILY INJURY)			X	
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	

Personal Policies

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
PPHO	LIAB	**BODI** (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOB BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
PPFM (FARMOWNERS)	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
PPFM (cont.)		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	BODI (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	BISF (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	PINJ (PERSONAL INJURY)	BODI (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
PPMH (MOBILE HOME)	LIAB (LIABILITY)	BISF (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
PPMH (continued)	LIAB (LIABILITY)	OTPI (OTHER PERSONAL INJURY)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	BODI (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	BISF (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		TRSM (TERRORISM)			X	
		OTCA (OTHER CASUALTY)			X	
	PINJ (PERSONAL INJURY)	BODI (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
PLMA (*) (PERSONAL LIABILITY MARINE)	LIAB (LIABILITY)	BODI (BODILY INJURY)	(*)PLMA – Personal Liability Marine, for liability and bodily injury under personal marine policies		X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	OTLB (OTHER LIABILITY)	BODI (BODILY INJURY)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		ENVR (ENVIRONMENTAL)			X	
		TRSM (TERRORISM)			X	
		MPAY (MEDICAL PAYMENTS)		X		
	PTCI (PROTECTION & INDEMNITY)	**BODI** (BODILY INJURY)			X	
BOAT (BOAT POLICIES)	**LIAB** (LIABILITY)	**BODI** (BODILY INJURY)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
PAPP (*) PERSONAL AUTO)	**BODI** (BODILY INJURY)	**BODI** (BODILY INJURY)	**(*)PAPP –** Personal Auto Policy ; policies written on operation or use of a personal auto, or personal vehicles covered under Personal Auto policies. Includes first party coverage for bodily injury and injury coverage on a third party basis; includes underinsured and uninsured motorist coverage, and No Fault or Med Map coverage based on local jurisdiction.		X	
		MPAY (MEDICAL PAYMENTS)		X		

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		NFLT (PIP)		X		
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	**MPAY (*)** (MEDICAL PAYMENTS)	**(*)MPAY** - Medical Payments coverage; can be Med Pay, no fault or other medical payments.	X		
		BODI (*) (BODILY INJURY)	**(*) BODI** – Bodily Injury; coverage provided for Liability Bodily Injury and Medical Payments coverage.	X		
		NFLT (NO FAULT)		X		
		OTAU (OTHER AUTO)		X		
	NFLT (PIP) (*) (NO FAULT)	**BODI** (BODILY INJURY)	**(*) NFLT** – No Fault coverage; can be PIP or other no fault medical payments coverage.	X		
		NFLT (PIP)		X		
		OTAU (OTHER AUTO)		X		
	OTAU (*) (OTHER AUTO)	**BODI** (BODILY INJURY)	**(*) OTAU** – Other Auto; coverage for non-owned auto, or can be used where other coverage is not included in coverage types.		X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		MPAY (MEDICAL PAYMENTS)		X		
		NFLT (PIP)		X		
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	
	UNDR (UNDER-INSURED MOTORIST)	**BODI** (BODILY INJURY)			X	
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	
	UNIN (UNINSURED MOTORIST)	**BODI** (BODILY INJURY)			X	
		OTAU (OTHER AUTO)			X	
		TRSM (TERRORISM)			X	

Workers Compensation

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
WCEL (*) (WORKERS COMP & EMPLOYERS LIABILITY)	**WCIL** (WORKERS COMP INDEMNITY)	**WCIL** (WORKERS COMP INDEMNITY)	**(*)WCEL –** Workers Comp; all coverages under Workers Compensation, including Employers Liability.			X
	WCLL (WORKERS COMP LIABILITY)	**WCLL** (WORKERS COMP LIABILITY)				X
	WCML (WORKERS COMP MEDICAL)	**WCML** (WORKERS COMP MEDICAL)				X
WCMA (WORKERS COMP MARINE)	**WCIL** (WORKERS COMP INDEMNITY)	**WCIL** (WORKERS COMP INDEMNITY)				X
	WCLL (WORKERS COMP LIABILITY)	**WCLL** (WORKERS COMP LIABILITY)				X
	WCML (WORKERS COMP MEDICAL)	**WCML** (WORKERS COMP MEDICAL)				X

Accident and Health

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
ACHE(*) ACCIDENT AND HEALTH	DISB(*) DISABILITY	DISB	(*)ACHE – Accident & Health; accident policies written by Property and Casualty insurers. NOTE: Use this policy type for Occupational Injury Claims. (*)DISB – Disability; disability coverage under Accident and Health policies written by Property Casualty coverages. NOTE: Use for Occupational Injury claims.	X		
	HEAL	HEAL	Health Claims under Property and Casualty Policies	X		

WEB Universal Format Reporting

In some instances, the ClaimSearch Universal Format website builds different policy/coverage/loss types on the backend than what is normally coded by system-to-system customers. Below are the codes (when different from the codes listed on the chart above) which are created by web entry. ***These codes SHOULD NOT BE PROGRAMMED by system-to-system companies.*** These codes are only being provided for reference purposed if they appear on a Pre-Query extract file for web-reported claims and you need to know the translation of the codes.

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
CLMP COMMERCIAL LIABILITY MULTI PERIL	**DRCT** (DIRECTORS & OFFICERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	EROM (ERRORS & OMISSIONS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	ERPL (EMPLOYERS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	LIAB (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRON-MENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRON-MENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER CASUALTY)			X	
		OTPI (*) (OTHER PERSONAL INJURY			X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	
		ENVR (ENVIRON-MENTAL)			X	
		OTCA (OTHER)			X	
	PROD (*)(PRODUCTS & COMPLETED OPERATIONS)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
	PTCI (PROTECTION & INDEMNITY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
CFRL COMMERCIAL FARM LIABILITY		**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENT AL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	MPAY (MEDICAL PAYMENTS	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)		X		
	OTLB (OTHER LIABILITY)	**BODI** (BODILY INJURY)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	POLL (POLLUTION)	**BODI** (BODILY INJURY)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
COML COMMERCIAL OCEAN MARINE LIABILITY	**LIAB** (LIABILITY)	**OTCA** (OTHER)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		MPAY (MEDICAL PAYMENTS		X		
		OTCA (OTHER CASUALTY)			X	
	PTCI (PROTECTION & INDEMNITY)	**BODI** (BODILY INJURY)			X	
CAVL COMMERCIAL AVIATION LIABILITY	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
PLMH PERSONAL MOBILE HOME LIABILITY	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	**BODI** (BODILY INJURY)		X		
		MPAY (MEDICAL PAYMENTS)		X		
	OTLB (OTHER LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRON-MENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		TRSM (TERRORISM)			X	
		OTCA (OTHER CASUALTY)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	
PLFM PERSONAL FARM LIABILITY	**LIAB** (LIABILITY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY			X	
		DOGB (DOG BITE)			X	

Policy	Coverage	Loss Type	Comments	Ongoing Medical (No Fault) (ORM)	Liability (TPOC)	WC
		ENVR (ENVIRONMENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	MPAY (MEDICAL PAYMENTS)	**MPAY** (MEDICAL PAYMENTS)		X		
		BODI (BODILY INJURY)		X		
	OTLB (OTHER LIABILTIY)	**BISF** (SLIP & FALL)			X	
		BODI (BODILY INJURY)			X	
		DOGB (DOG BITE)			X	
		ENVR (ENVIRON-MENTAL)			X	
		MPAY (MEDICAL PAYMENTS)		X		
		OTCA (OTHER)			X	
		TRSM (TERRORISM)			X	
	PINJ (PERSONAL INJURY)	**BODI** (BODILY INJURY)			X	
		OTCA (OTHER)			X	
		OTPI (OTHER PERSONAL INJURY)			X	

Legacy Casualty Format

Below are the legacy claim types which qualify for CMS Query and Reporting.

HOL	Homeowners Liability
MP	Homeowners Med Pay
GL	General Liability
WC	Workers Compensation
AUTO	Auto Liability Bodily Injury
AMP	Auto Med Pay
PIP	Auto No Fault
DIS	Disability
N/RPT	Other

APPENDIX B – LAYOUT FOR QUERY RESPONSE FILE

Record NGQR – Non Group Health Query Response File Record

If multiple claims are found in the ISO ClaimSearch database with the same SSN, this record will be repeated for each claim found.

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGQR	Record Identifier	4	A/N	Contains value of "NGQR'
11-40		Claim Number	30	A/N	Claim Number assigned to loss
41-49		Insuring Company Code	9	A/N	The customer ID code assigned by ClaimSearch
50-61		Health Insurance Claim Number (HICN)	12	A/N	Applied Medicare Health Insurance Claim Number.
62-67		Last Name	6	A/N	Applied Surname of Individual/Injured Party. Updated with Medicare information if the individual is identified as a Medicare beneficiary based upon the information submitted.
68		First Initial	1	A/N	Applied First Initial of Individual/Injured Party. Updated with Medicare information if the individual is identified as a Medicare beneficiary based upon the information submitted.
69-76		Date of Birth	8	N	Applied Individual's Date of Birth (YYYYMMDD). Updated with Medicare information if the individual is identified as a Medicare beneficiary based upon the information submitted.
77		Gender	1	N	Applied Covered individual's gender: 0 = unknown 1 = male 2 = female Updated with Medicare information if the individual is identified as a Medicare beneficiary based upon the information submitted.
78-86		SSN	9	N	Social Security Number of the Individual as submitted by the RRE on the input record. Note: If both a HICN and an SSN were submitted on the input file and CMS matched on the HICN, CMS takes no action to validate the SSN. The first 5 positions of the SSN will be masked (zero-filled).
87-97		ISO File Number	11	A/N	Claim Identifier
98-127		Policy Number	30	A/N	Policy Number assigned to loss
128-135		Date of Loss	8	N	YYYYMMDD
136-205		Adjuster Name	70	A/N	
206-275		Insured Name	70	A/N	

Position			Length	Type	Description
276-305		Submitted Claimant Last Name	30	A/N	
306-325		Submitted Claimant First Name	20	A/N	
326-337		Submitted Claimant Middle Name	12	A/N	
338-357		Routing/Miscellaneous Info	20	A/N	
358		Claim Source	1	A/N	L = legacy; U = Universal Format
359		Reported Source	1	A/N	Universal Format system-to-system methods (F = FTP; L = XML, Q = MQ) Legacy system-to-system methods (F = FTP, I = IIN, O = Online, T = Tape, X = Tracs, 3 = 3780) W = Web D = paper (data entry) A = legacy ACE software
360		Filler	241	A/N	Spaces

Record NGQH – Non Group Health Query Response File Header Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGQH	Record Identifier	4	A/N	Contains value of 'NGQH'
11-17		Reporting File Type	7	A/N	Contains value of 'NGHPQRS'
18-26		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
27-34		Date file was sent to CMS	8	N	Date the input file was sent to CMS. Format: YYYYMMDD
35-42		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
43-600		Filler	558	A/N	Spaces

Record NGQT – Non Group Health Query Response File Trailer Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGQT	Record Identifier	4	A/N	Contains value of 'NGQT'
11-19		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
20-27		Date file was sent to CMS	8	N	Date the input file was sent to CMS.

					Format: YYYYMMDD
28-35		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
Position			**Length**	**Type**	**Description**
36-42		File Record Count	7	N	Number of detail response records contained within file (does not include header or trailer records).
43-600		Filler	558	A/N	Spaces

APPENDIX C – LAYOUT FOR ACKNOWLEDGEMENT FILE

RECORD NGRD – Non Group Health Response File Detail Record

Position			Length	Type	Description
INFORMATION PROVIDED BY ISO CLAIMSEARCH					
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGRD	Record Identifier	4	A/N	Contains value of "NGRD'
11-40		Claim Number	30	A/N	Claim Number assigned to loss
41-49		Insuring Company Code	9	A/N	The customer ID code assigned by ClaimSearch
50-64		Document Control Number	15	A/N	The DCN assigned by ISO.
ECHO OF INPUT INFORMATION					
65		Submitted Action Type	1	N	Action performed. 0=Add 1 = Delete 2 = Update/Change
66-77		Submitted Injured Party HICN	12	A/N	Health Insurance Claim Number (HICN) of Injured Party (as supplied on input)
78-86		Submitted Injured Party SSN	9	N	Social Security Number of Injured Party (as supplied on input). The first 5 positions of the SSN will be masked (zero-filled).
87-126		Submitted Injured Party Last Name	40	A/N	As supplied on input record

Position			Length	Type	Description
127-156		Submitted Injured Party First Name	30	A/N	As supplied on input record.
157		Submitted Injured Party Middle Init	1	A/N	As supplied on input record.
158		Submitted Injured Party Gender	1	N	1 = Male 2 = Female 0 = Unknown
159-166		Submitted Injured Party DOB	8	N	Format: YYYYMMDD
167-175		Submitted Plan TIN	9	N	As supplied on input record.
176-184		Submitted Plan Site ID	9	A/N	As supplied on input record.
185-196		Applied Injured Party HICN	12	A/N	Current HICN of Injured Party if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
197-236		Applied Injured Party Last Name	40	A/N	Injured Party Last Name, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
237-266		Applied Injured Party First Name	30	A/N	Injured Party First Name, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
267		Applied Injured Party Middle Initial	1	A/N	Injured Party Middle Initial, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
268		Applied Injured Party Gender	1	A/N	Gender of Injured Party, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied. 1 = Male 2 = Female

Position			Length	Type	Description
269-276		Applied Injured Party DOB	8	N	Date of Birth of Injured Party, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied. Format: YYYYMMDD
277-284		Applied MSP Effective Date	8	N	Applied Medicare Secondary Payer (MSP) effective date, if identified as a Medicare beneficiary based upon the information submitted, and the claim information reflects ORM, the start date of Medicare's secondary payment status for the incident, illness or injury. Will be the later of the beneficiary's Medicare entitlement/eligibility start date or the CMS Date of Incident. This is the effective date of the MSP occurrence posted to the internal Medicare systems which are used in Medicare claim payment determinations. Will contain all zeroes if not applicable. COBC supplied. Format: YYYYMMDD.
285-292		Applied MSP Termination Date	8	N	Applied Medicare Secondary Payer (MSP) termination date, if identified as a Medicare beneficiary based upon the information submitted, the date posted to internal Medicare systems for the termination of responsibility for ongoing medicals as reported by the RRE. Will contain all zeroes if open-ended or not applicable. COBC supplied. Format: YYYYMMDD.
293		Applied MSP Type Indicator	1	A/N	Applied Medicare Secondary Payer (MSP) Type. COBC supplied. D = No-Fault E = Workers' Compensation L = Liability

Position			Length	Type	Description
294-295		Applied Disposition Code	2	A/N	2-digit code indicating how the record was processed. COBC supplied. 01 = Record accepted by the COBC. RRE has indicated ongoing responsibility for medicals. 02 = Record accepted by the COBC. RRE has indicated no ongoing responsibility for medicals. 03 = Record accepted by the COBC. The injured party was identified as a Medicare beneficiary based on the information submitted, but the beneficiary did not have Medicare coverage during the reported time period.
296-297		Applied Compliance Flag 1	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.

Position			Length	Type	Description
298-299		Applied Compliance Flag 2	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.
300-301		Applied Compliance Flag 3	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.

Position			Length	Type	Description
302-303		Applied Compliance Flag 4 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.
304-305		Applied Compliance Flag 5 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.

Position			Length	Type	Description
306-307		Applied Compliance Flag 6 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.
308-309		Applied Compliance Flag 7 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.

Position			Length	Type	Description
310-311		Applied Compliance Flag 8 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.
312-313		Applied Compliance Flag 9 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.

Position			Length	Type	Description
314-315		Applied Compliance Flag 10 (for future expansion; currently there are only 3 compliance flags).	2	A/N	Code indicating compliance issue found with record. COBC supplied. 01 – Late submission of TPOC. TPOC date more than 135 days older than the start date of the current file submission period. 02 – An invalid RRE TIN was supplied. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. (You must contact ISO ClaimSearch with the correct TIN information to be used on future files). 03 – Late Submission of ORM Termination Date. ORM Termination Date more than 135 days older than the start date of the current file submission period.
316-319		Coverage Type	4	A/N	Coverage Type reported on ClaimSearch claim. NOTE: For Plan D (No Fault) type claims which are combinable when reported to CMS, the Coverage Type reported will not be sent back to you; you will receive a Coverage Type of COMB indicating that the coverage may have been combined.
320-323		Loss Type	4	A/N	Loss Type reported on ClaimSearch claim. NOTE: For Plan D (No Fault) type claims which are combinable when reported to CMS, the Loss Type reported will not be sent back to you; you will receive a Loss Type of COMB indicating that the coverage may have been combined.
324-334		ISO File Number	11	A/N	ISO Claim Identifier
335-364		Policy Number	30	A/N	Policy assigned to loss

Position			Length	Type	Description
365-372		Date of Loss	8	N	YYYYMMDD
373-442		Adjuster Name	70	A/N	
443-512		Insured Name	70	A/N	
513-532		Routing/Misc.	20	A/N	
533-600		Filler	68	A/N	Spaces

Record NGRH – Non Group Health Response File Header Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGRH	Record Identifier	4	A/N	Contains value of 'NGRH'
11-17		Reporting File Type	7	A/N	Contains value of 'NGHPRSP'
18-26		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
27-34		Date file was sent to CMS	8	N	Date the input file was sent to CMS. Format: YYYYMMDD
35-42		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
43-600		Filler	558	A/N	Spaces

Record NGRT – Non Group Health Response File Trailer Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGRT	Record Identifier	4	A/N	Contains value of 'NGRT'
11-19		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
20-27		Date file was sent to CMS	8	N	Date the input file was sent to CMS. Format: YYYYMMDD
28-35		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
36-42		File Record Count	7	N	Number of detail response records contained within file (does not include header or trailer records).
43-600		Filler	558	A/N	Spaces

APPENDIX D – LAYOUT FOR REJECT FILE

Record NGED – Non Group Health Error File Detail Record

Position			Length	Type	Description
INFORMATION PROVIDED BY ISO CLAIMSEARCH					
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGED	Record Identifier	4	A/N	Contains value of 'NGED'.
11-40		Claim Number	30	A/N	Claim Number assigned to loss
41-49		Insuring Company Code	9	A/N	The customer ID code assigned by ClaimSearch
50-64		Document Control Number	15	A/N	The DCN assigned by ISO.
ECHO OF INPUT INFORMATION					
65		Submitted Action Type	1	N	Action performed (as submitted on input) . 0=Add 1 = Delete 2 = Update/Change
66-77		Submitted Injured Party HICN	12	A/N	Health Insurance Claim Number (HICN) of Injured Party (as supplied on input)
78-86		Submitted Injured Party SSN	9	N	Social Security Number of Injured Party (as supplied on input). The first 5 positions of the SSN will be masked (zero-filled).
87-126		Submitted Injured Party Last Name	40	A/N	As supplied on input record
127-156		Submitted Injured Party First Name	30	A/N	As supplied on input record.
157		Submitted Injured Party Middle Init	1	A/N	As supplied on input record.

Position			Length	Type	Description
158		Submitted Injured Party Gender	1	N	1 = Male 2 = Female 0 = Unknown
159-166		Submitted Injured Party DOB	8	N	Format: YYYYMMDD
167-175		Submitted Plan TIN	9	N	As supplied on input record.
176-184		Submitted Plan Site ID	9	A/N	As supplied on input record.
REJECTION INFORMATION FROM COBC					
185-186		Applied Disposition Code	2	A/N	2 digit code indicating how the record was processed. SP = Record not accepted by the COBC due to errors in the data reported. Record returned with at least one error code. Record must be corrected and resubmitted on the next quarterly file submission. 50 = Record still being processed by CMS. Record must be resubmitted on the next quarterly file submission. 51 = Individual was not identified as a Medicare Beneficiary.
187-191		Error Code 1	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
192-196		Error Code 2	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
197-201		Error Code 3	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.

Position			Length	Type	Description
202-206		Error Code 4	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
207-211		Error Code 5	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
212-216		Error Code 6	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
217-221		Error Code 7	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
222-226		Error Code 8	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
227-231		Error Code 9	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
232-236		Error Code 10	5	A/N	Code associated with an error found by the COBC in the submitted record. See Appendix A.
237-240		Coverage Type	4	A/N	Coverage Type reported on ClaimSearch claim. NOTE: For Plan D (No Fault) type claims which are combinable when reported to CMS, the Coverage Type reported will not be sent back to you; you will receive a Coverage Type of COMB indicating that the coverage may have been combined.
241-244		Loss Type	4	A/N	Loss Type reported on ClaimSearch claim. NOTE: For Plan D (No Fault) type claims which are combinable when reported to CMS, the Loss Type reported will not be sent back to you; you will receive a Loss Type of COMB indicating that the coverage may have been combined.
245-255		ISO File Number	11	A/N	ISO Claim Identifier

Position			Length	Type	Description
256-285		Policy Number	30	A/N	Policy assigned to loss
286-293		Date of Loss	8	N	YYYYMMDD
294-363		Adjuster Name	70	AN	
364-433		Insured Name	70	A/N	
434-453		Routing/Misc.	20	A/N	
454-600		Filler	147	A/N	Spaces

Record NGEH – Non Group Health Error File Header Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGEH	Record Identifier	4	A/N	Contains value of 'NGEH'
11-17		Reporting File Type	7	A/N	Contains value of 'NGHPERR'
18-26		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
27-34		Date file was sent to CMS	8	N	Date the input file was sent to CMS.
35-42		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
43-600		Filler	558	A/N	Spaces

Record NGET – Non Group Health Error File Trailer Record

Position			Length	Type	Description
1-6		Sequence Number	6	A/N	A computer-generated sequential number for each physical record in a file including the header, trailer and detail records, beginning with 000001.
7-10	NGET	Record Identifier	4	A/N	Contains value of 'NGET'
11-19		Section 111 Reporter ID (RRE Code)	9	A/N	COBC assigned Section 111 Reporter ID.
20-27		Date file was sent to CMS	8	N	Date the input file was sent to CMS
28-35		Date file was posted by CMS	8	N	Date file was posted by CMS. This may not be the same date that ISO posted the file. Format: YYYYMMDD
36-42		File Record Count	7	N	Number of detail response records contained within file (does not include header or trailer records).
43-600		Filler	558	A/N	Spaces

Error Codes – **For a complete list of error codes, please refer to the CMS User Guide. ISO provides the information below as a resource, however, the CMS User Guide should be the primary source for this information since ISO's manual may not contain all updates provided by CMS.**

Error Code	Field	Description
CB01	Detail or Auxiliary Record Identifier	Required. Must be equal to 'NGCD' (Claim Input File Detail Record) or 'NGCE' (Claim Input File Auxiliary Record). 'NGCE' must always follow an 'NGCD' record. If 'NGCE' record submitted, DCN/HICN/SSN/Injured Party First Name/Injured Party Last Name must match values on the 'NGCD' record.
CB02	DCN	Required. Field must contain value greater than spaces. Value on each detail record must be unique within the file submission.
CB03	Action Type	Required. Field must contain a numeric character. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record, 1 = Delete Record, 2 = Update Record.
CB04	Injured Party HICN	Field must contain spaces or alphanumeric characters. No dashes or hyphens allowed.
CB05	Injured Party SSN	Field must contain all spaces or a numeric value. No dashes, hyphens or special characters allowed.
CB06	Injured Party HICN/SSN	A valid Injured Party HICN or Injured Party SSN must be provided.
CB07	Injured Party Last Name	Required. First position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space. Submit as shown on Social Security or Medicare Card.
CB08	Injured Party First Name	Required. Must contain letters or spaces. Submit as shown on Social Security or Medicare Card.
CB09	Injured Party Middle Init	Optional. Field must contain an alphabetic character or space. No other characters allowed.
CB10	Injured Party Gender	Required. Field must contain a numeric character. Field cannot be spaces or alpha characters. Acceptable numeric characters include the following: 0 = Unknown, 1 = Male, 2 = Female.
CB11	Injured Party DOB	Required. Field must be numeric and contain a valid date prior to the current date. Formatted as CCYYMMDD. Field cannot contain spaces, alpha characters or all zeroes.
CI01	CMS Date of Incident	Required. Field must be numeric and a valid date prior to or equal to the current date. Formatted as CCYYMMDD. Field cannot contain spaces, alpha characters or all zeroes.
CI02	Industry Date of Incident	Optional. Edit bypassed if field equal to all zeroes. Field must be numeric and contain a valid date prior to or equal to the current date or equal to zeroes. Formatted as CCYYMMDD.
CI03	Alleged Cause of Injury	Required for Add and Update records (Action Type = 0 or 2) as of 01/01/2011. If field is equal to spaces prior to 01/01/2011 edit bypassed. First position must be 'E'. Field must contain a valid ICD-9-CM 'E' Code after 1/1/2011. May equal to spaces prior to 1/1/2011. Must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not include decimal point.

Error Code	Field	Description
CI04	State of Venue	Required. Must be a valid US Postal state abbreviation (www.usps.com/ncsc/lookups/abbreviations.html), a value of 'US', or a value of 'FC'.
CI05	ICD-9 Diagnosis Code 1	Required for Add and Update records (Action Type = 0 or 2) as of 01/01/2011. May equal spaces prior to 1/1/2011. If field is equal to spaces prior to 01/01/2011 edit bypassed. Must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI06	ICD-9 Diagnosis Code 2	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI07	ICD-9 Diagnosis Code 3	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI08	ICD-9 Diagnosis Code 4	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI09	ICD-9 Diagnosis Code 5	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI10	ICD-9 Diagnosis Code 6	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI11	ICD-9 Diagnosis Code 7	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI12	ICD-9 Diagnosis Code 8	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI13	ICD-9 Diagnosis Code 9	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.

Error Code	Field	Description
CI14	ICD-9 Diagnosis Code 10	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI15	ICD-9 Diagnosis Code 11	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI16	ICD-9 Diagnosis Code 12	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI17	ICD-9 Diagnosis Code 13	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI18	ICD-9 Diagnosis Code 14	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI19	ICD-9 Diagnosis Code 15	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI20	ICD-9 Diagnosis Code 16	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI21	ICD-9 Diagnosis Code 17	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI22	ICD-9 Diagnosis Code 18	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.

Error Code	Field	Description
CI23	ICD-9 Diagnosis Code 19	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on one of the 3 most current lists of valid ICD-9 diagnosis codes at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not be on the list of "Excluded Codes" in Appendix H. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point.
CI24	Description of Illness/Injury	Required on Add and Update records (Action Type = 0 or 2) if ICD-9-CM Diagnosis Code 1 and Alleged Cause of Injury not both provided and prior to 01/01/2011. If required must contain alphanumeric characters and not equal to spaces.
CI25	ICD-9 Diagnosis and Alleged Cause of Injury	Prior to 01/01/2011, at least a valid ICD-9 Diagnosis Code 1 and a valid Alleged Cause of Injury must be provided or Description of Illness/Injury must be provided. After 12/31/2010, both a valid ICD-9 Diagnosis Code 1 and a valid Alleged Cause of Injury must be provided.
CI26	Product Liability Indicator	Not used.
CI27	Product Generic Name	Not used.
CI28	Product Brand Name	Not used.
CI29	Product Manufacturer	Not used.
CI30	Product Alleged Harm	Not used.
CS01	Self Insured Indicator	Required if Plan Insurance Type equal to 'E' or 'L'. If required, value must be equal to 'Y' or 'N'. If not required (Plan Insurance Type equals 'D') must equal space or 'N'.
CS02	Self Insured Type	Required if Self Insured Indicator equal to 'Y'. If required, value must equal to "I or 'O'. If not required must equal space.
CS03	Policyholder Last Name	Required when Self Insured Type equal to 'I'. If required, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space. Field must be equal to spaces if Self Insured type not equal to 'I'.
CS04	Policyholder First Name	Required when Self Insured Type equal to 'I'. If required must contain letters or spaces. Field must be equal to spaces if Self Insured Type is not equal to 'I'.
CS05	DBA Name	Field must be equal to spaces if Self Insured Type is equal to 'I'. If greater than spaces, field must contain at least 2 alphanumeric characters.
CS06	Legal Name	Field must be equal to spaces if Self Insured Type is equal to 'I'. If greater than spaces, field must contain at least 2 alphanumeric characters.
CS07	DBA/Legal Name	DBA or Legal name must be provided if Self Insured Type is equal to 'O'.
CP01	Plan Insurance Type	Required. Must contain one of the following alpha characters: 'D' = No-Fault, 'E' = Workers' Compensation, 'L' = Liability.
CP02	TIN	Required. Must contain a valid 9-digit IRS-assigned Federal Tax Identification Number or foreign RRE pseudo-TIN. A corresponding TIN record must have been submitted on the TIN Reference File. Must be numeric. Include leading zeroes. Do not include hyphens.

Error Code	Field	Description
CP03	Office Code/Site ID	Optional. Must be equal to spaces or must contain a 9-digit numeric code. Must have a corresponding entry with associated TIN on the TIN Reference File. A record must be submitted on the TIN Reference File for each unique TIN/Office Code combination.
CP04	Policy Number	Required. Must be at least 3 characters in length. Acceptable characters (alpha, numeric, space, comma, & - ' . @ # / ; or :). Cannot be equal to all spaces.
CP05	Claim Number	Required. Must contain alphanumeric values and cannot be equal to spaces.
CP06	Plan Contact Department Name	Optional. Field may contain alphanumeric characters. If field is not used, field must contain spaces.
CP07	Plan Contact Last Name	Optional. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CP08	Plan Contact First Name	Optional. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
CP09	Plan Contact Phone	Optional. Must contain 10-digit numeric value or zeroes if not provided.
CP10	Plan Contact Phone Extension	Optional. Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided.
CP11	No-Fault Insurance Limit	Must contain a numeric value or all zeroes. If Plan Insurance Type is equal to 'D', a value greater than zeroes must be provided. Fill with all 9's if there is no dollar limit. Fill with zeroes if Plan Insurance Type is 'E' or 'L'.
CP12	Exhaust Date for No-Fault Insurance Limit	Must contain zeroes or a valid date. If Plan Insurance Type is equal to an 'E' or 'L', must contain zeroes.
CP13	TIN/Office Code Mailing Name	Required. Field must contain at least 2 alphanumeric characters. If the Insurer's plan name is equal to SUPPLEMENT, SUPPLEMENTAL, INSURER, MISCELLANEOUS, CMS, ATTORNEY, UNKNOWN, NONE, N/A, UN, MISC, NO, BC, BX, BS, BCBX, BLUE CROSS, BLUE SHIELD, or MEDICARE the CP13 error will be applied. Extracted from TIN Reference file.
CP14	TIN/Office Code Mailing Address Line 1	Required. Field must contain alphanumeric characters. Field cannot be blank or equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If TIN/Office Code State is 'FC', must be blank. Extracted from TIN Reference file.

Error Code	Field	Description
CP15	TIN/Office Code Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If TIN/Office Code State is 'FC', must be blank. Extracted from TIN Reference file.
CP16	TIN/Office Code City	Required. Embedded spaces are allowed for multi-word city name. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If TIN/Office Code State is 'FC', must be blank. Extracted from TIN Reference file.
CP17	TIN/Office Code State	Required. Field must contain US Postal Abbreviation Code or 'FC'. See www.usps.com/ncsc/lookups/abbreviations.html. Extracted from TIN Reference file.
CP18	TIN/Office Code Zip	Required. Field must contain a valid 5-digit numeric US Zip Code. If TIN/Office Code State is 'FC', must be blank. Extracted from TIN Reference file.
CP19	TIN/Office Code Zip+4	Field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If TIN/Office Code State is 'FC', must be zeroes. Extracted from TIN Reference file.
CP20	Foreign RRE Address Line 1	If TIN/Office Code State is not 'FC', must be equal to spaces. If TIN/Office Code State is 'FC', must contain at least one non-blank character.
CP21	Foreign RRE Address Line 2	If TIN/Office Code State is not 'FC', must be equal to spaces. If TIN/Office Code State is 'FC', must be blank or valid alphanumeric characters.
CP22	Foreign RRE Address Line 3	If TIN/Office Code State is not 'FC', must be equal to spaces. If TIN/Office Code State is 'FC', must be blank or valid alphanumeric characters.
CP23	Foreign RRE Address Line 4	If TIN/Office Code State is not 'FC', must be equal to spaces. If TIN/Office Code State is 'FC', must be blank or valid alphanumeric characters.
CR01	Injured Party Representative Indicator	Must be an alpha value of: 'A' = Attorney, 'G' = Guardian, 'P' = Power of Attorney, 'O' = Other, Space = None.
CR02	Representative Last Name	If Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR03	Representative First Name	If Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.

Error Code	Field	Description
CR04	Representative Firm Name	If Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR05	Representative TIN	May contain a 9-digit number, all zeroes or all spaces.
CR06	Representative Mailing Address Line 1	Required if Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Representative Indicator is equal to spaces, field must be equal to spaces. If Representative State = 'FC', field must be equal to all spaces.
CR07	Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR08	Representative City	Required if Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Representative State = 'FC', field must be equal to all spaces
CR09	Representative State	If Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Representative Indicator equal to spaces, field must be equal to spaces.
CR10	Representative Mail Zip Code	If Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Representative Indicator equal to spaces, field must be equal to zeroes. If Representative State = 'FC', field must be equal to all zeroes.
CR11	Representative Mail Zip+4	If Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If Representative Indicator equal to spaces, field must be equal to zeroes. If Representative State = 'FC', field must be equal to all zeroes.
CR12	Representative Phone	If Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Representative Indicator equal to spaces, field must be equal to zeroes. If Representative State = 'FC', field must be equal to all zeroes.
CR13	Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Representative Indicator equal to spaces, field must be equal to spaces.
CR14	Representative Name/Firm Name	Either Representative Last Name *and* Representative First Name – or – Representative Firm Name is required, if Representative Indicator is not equal to spaces.

Error Code	Field	Description
CJ01	ORM Indicator	Required. Must contain a value of 'Y' or 'N'.
CJ02	ORM Termination Date	Must contain a valid date or zeroes. Must be all zeroes if ORM Indicator = 'N'. Future dates are allowed.
CJ03	TPOC Date 1	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date). Required if a non-zero TPOC Amount 1 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be zero if TPOC Amount 1 is zero.
CJ04	TPOC Amount 1	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 1 is supplied. Must be zero if TPOC Date 1 is zero.
CJ05	Funding Delayed Beyond TPOC Start Date 1	Must contain a valid date or zeroes.
CJ06	DOI/ORM Termination Date	ORM Termination Date must be at least 30 days after the CMS Date of Incident. Cannot be more than 6 months greater than the file submission date.
CJ07	TPOC Threshold	Total of TPOC Amounts reported on Add record (Action Type = 0) with ORM Indicator = 'N' does not exceed interim reporting threshold.
CC01	Claimant 1 Relationship	Must be an alpha value of: E = Estate, Individual Name, F = Family, Individual Name, O = Other, Individual Name, X = Estate, Entity Name, Y = Family, Entity Name, Z = Other, Entity Name, Space = Not Applicable.
CC02	Claimant 1 TIN	If Claimant 1 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. May contain a 9-digit number, all zeroes or all spaces. Must not match other Claimant TINs.
CC03	Claimant 1 Last Name	If Claimant 1 Relationship equal to space, field must be equal to spaces. If Claimant 1 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CC04	Claimant 1 First Name	If Claimant 1 Relationship equal to space, field must be equal to spaces. . If Claimant 1 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC05	Claimant 1 Middle Initial	Field must be equal to space or an alpha character. If Claimant 1 Relationship equal to space, field must be equal to space.
CC06	Claimant 1 Mailing Address Line 1	Required if Claimant 1 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 1 Relationship is equal to spaces, field must be equal to spaces. If Claimant 1 State = 'FC', field must be equal to all spaces

Error Code	Field	Description
CC07	Claimant 1 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CC08	Claimant 1 City	Required if Claimant 1 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 1 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 1 State = 'FC', field must be equal to all spaces
CC09	Claimant 1 State	If Claimant 1 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 1 Relationship equal to spaces, field must be equal to spaces.
CC10	Claimant 1 Zip	If Claimant 1 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 1 Relationship equal to spaces, field must be equal to zeroes. If Claimant 1 State = 'FC', field must be equal to all zeroes.
CC11	Claimant 1 Zip+4	If Claimant 1 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 1 Relationship equal to spaces, field must be equal to zeroes. If Claimant 1 State = 'FC', field must be equal to all zeroes.
CC12	Claimant 1 Phone	If Claimant 1 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 1 Relationship equal to spaces, field must be equal to zeroes. If Claimant 1 State = 'FC', field must be equal to all zeroes.
CC13	Claimant 1 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 1 Relationship equal to spaces, field must be equal to spaces.
CC14	Claimant 1 Entity/Organization Name	If Claimant 1 Relationship equal to space, field must contain spaces. If Claimant 1 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.
CC21	Claimant 2 Relationship	Must be an alpha value of: E = Estate, Individual Name, F = Family, Individual Name, O = Other, Individual Name, X = Estate, Entity Name, Y = Family, Entity Name, Z = Other, Entity Name, Space = Not Applicable.
CC22	Claimant 2 TIN	If Claimant 2 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. May contain a 9-digit number, all zeroes or all spaces. Must not match other Claimant SSNs.
CC23	Claimant 2 Last Name	If Claimant 2 Relationship equal to space, field must be equal to spaces. If Claimant 2 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.

Error Code	Field	Description
CC24	Claimant 2 First Name	If Claimant 2 Relationship equal to space, field must be equal to spaces. . If Claimant 2 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC25	Claimant 2 Middle Initial	Field must be equal to space or an alpha character. If Claimant 2 Relationship equal to space, field must be equal to space.
CC26	Claimant 2 Mailing Address Line 1	Required if Claimant 2 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 2 Relationship is equal to spaces, field must be equal to spaces. If Claimant 2 State = 'FC', field must be equal to all spaces
CC27	Claimant 2 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CC28	Claimant 2 City	Required if Claimant 2 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 2 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 2 State = 'FC', field must be equal to all spaces
CC29	Claimant 2 State	If Claimant 2 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 2 Relationship equal to spaces, field must be equal to spaces.
CC30	Claimant 2 Zip	If Claimant 2 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 2 Relationship equal to spaces, field must be equal to zeroes. If Claimant 2 State = 'FC', field must be equal to all zeroes.
CC31	Claimant 2 Zip+4	If Claimant 2 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 2 Relationship equal to spaces, field must be equal to zeroes. If Claimant 2 State = 'FC', field must be equal to all zeroes.
CC32	Claimant 2 Phone	If Claimant 2 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 2 Relationship equal to spaces, field must be equal to zeroes. If Claimant 2 State = 'FC', field must be equal to all zeroes.
CC33	Claimant 2 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 2 Relationship equal to spaces, field must be equal to spaces.
CC34	Claimant 2 Entity/Organization Name	If Claimant 2 Relationship equal to space, field must contain spaces. If Claimant 2 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.

Error Code	Field	Description
CC41	Claimant 3 Relationship	Must be an alpha value of: E = Estate, Individual Name, F = Family, Individual Name, O = Other, Individual Name, X = Estate, Entity Name, Y = Family, Entity Name, Z = Other, Entity Name, Space = Not Applicable.
CC42	Claimant 3 TIN	If Claimant 3 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. May contain a 9-digit number, all zeroes or all spaces. Must not match other Claimant TINs.
CC43	Claimant 3 Last Name	If Claimant 3 Relationship equal to space, field must be equal to spaces. If Claimant 3 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CC44	Claimant 3 First Name	If Claimant 3 Relationship equal to space, field must be equal to spaces. . If Claimant 3 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC45	Claimant 3 Middle Initial	Field must be equal to space or an alpha character. f Claimant 3 Relationship equal to space, field must be equal to space.
CC46	Claimant 3 Mailing Address Line 1	Required if Claimant 3 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 3 Relationship is equal to spaces, field must be equal to spaces. If Claimant 3 State = 'FC', field must be equal to all spaces
CC47	Claimant 3 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CC48	Claimant 3 City	Required if Claimant 3 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 3 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 3 State = 'FC', field must be equal to all spaces
CC49	Claimant 3 State	If Claimant 3 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 3 Relationship equal to spaces, field must be equal to spaces.
CC50	Claimant 3 Zip	If Claimant 3 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 3 Relationship equal to spaces, field must be equal to zeroes. If Claimant 3 State = 'FC', field must be equal to all zeroes.
CC51	Claimant 3 Zip+4	If Claimant 3 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 3 Relationship equal to spaces, field must be equal to zeroes. If Claimant 3 State = 'FC', field must be equal to all zeroes.

Error Code	Field	Description
CC52	Claimant 3 Phone	If Claimant 3 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 3 Relationship equal to spaces, field must be equal to zeroes. If Claimant 3 State = 'FC', field must be equal to all zeroes.
CC53	Claimant 3 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 3 Relationship equal to spaces, field must be equal to spaces.
CC54	Claimant 3 Entity/Organization Name	If Claimant 3 Relationship equal to space, field must contain spaces. If Claimant 3 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.
CC61	Claimant 4 Relationship	Must be an alpha value of: E = Estate, Individual Name, F = Family, Individual Name, O = Other, Individual Name, X = Estate, Entity Name, Y = Family, Entity Name, Z = Other, Entity Name, Space = Not Applicable.
CC62	Claimant 4 TIN	If Claimant 4 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. May contain a 9-digit number, all zeroes or all spaces. Must not match other Claimant TINs.
CC63	Claimant 4 Last Name	If Claimant 4 Relationship equal to space, field must be equal to spaces. If Claimant 4 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CC64	Claimant 4 First Name	If Claimant 4 Relationship equal to space, field must be equal to spaces. . If Claimant 4 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC65	Claimant 4 Middle Initial	Field must be equal to space or an alpha character. If Claimant 4 Relationship equal to space, field must be equal to space.
CC66	Claimant 4 Mailing Address Line 1	Required if Claimant 4 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 4 Relationship is equal to spaces, field must be equal to spaces. If Claimant 4 State = 'FC', field must be equal to all spaces
CC67	Claimant 4 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CC68	Claimant 4 City	Required if Claimant 4 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 4 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 4 State = 'FC', field must be equal to all spaces

Error Code	Field	Description
CC69	Claimant 4 State	If Claimant 4 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 4 Relationship equal to spaces, field must be equal to spaces.
CC70	Claimant 4 Zip	If Claimant 4 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 4 Relationship equal to spaces, field must be equal to zeroes. If Claimant 4 State = 'FC', field must be equal to all zeroes.
CC71	Claimant 4 Zip+4	If Claimant 4 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 4 Relationship equal to spaces, field must be equal to zeroes. If Claimant 4 State = 'FC', field must be equal to all zeroes.
CC72	Claimant 4 Phone	If Claimant 4 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 4 Relationship equal to spaces, field must be equal to zeroes. If Claimant 4 State = 'FC', field must be equal to all zeroes.
CC73	Claimant 4 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 4 Relationship equal to spaces, field must be equal to spaces.
CC74	Claimant 4 Entity/Organization Name	If Claimant 4 Relationship equal to space, field must contain spaces. If Claimant 4 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.
CR21	Claimant 1 Representative Indicator	Must be an alpha value of: 'A' = Attorney, 'G' = Guardian, 'P' = Power of Attorney, 'O' = Other, Space = None.
CR22	Claimant 1 Representative Last Name	If C1 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR23	Claimant 1 Representative First Name	If C1 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
CR24	Claimant 1 Representative Firm Name	If C1 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR25	Claimant 1 Representative TIN	May contain a 9-digit number, all zeroes or all spaces.

Error Code	Field	Description
CR26	Claimant 1 Representative Mailing Address 1	Required if C1 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C1 Representative Indicator is equal to spaces, field must be equal to spaces. If C1 Representative State = 'FC', field must be equal to all spaces.
CR27	Claimant 1 Representative Mailing Address 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR28	Claimant 1 Representative Mailing City	Required if C1 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C1 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C1 Representative State = 'FC', field must be equal to all spaces
CR29	Claimant 1 Representative State	If C1 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C1 Representative Indicator equal to spaces, field must be equal to spaces.
CR30	Claimant 1 Representative Zip	If C1 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C1 Representative Indicator equal to spaces, field must be equal to zeroes. If C1 Representative State = 'FC', field must be equal to all zeroes.
CR31	Claimant 1 Representative Zip+4	If C1 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C1 Representative Indicator equal to spaces, field must be equal to zeroes. If C1 Representative State = 'FC', field must be equal to all zeroes.
CR32	Claimant 1 Representative Phone	If C1 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C1 Representative Indicator equal to spaces, field must be equal to zeroes. If C1 Representative State = 'FC', field must be equal to all zeroes.
CR33	Claimant 1 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C1 Representative Indicator equal to spaces, field must be equal to spaces.
CR34	Claimant 1 Representative Name/Firm Name	Either C1 Representative Last Name *and* C1 Representative First Name – or – C1 Representative Firm Name is required if C1 Representative Indicator is not equal to spaces.
CR41	Claimant 2 Representative Indicator	Must be an alpha value of: 'A' = Attorney, 'G' = Guardian, 'P' = Power of Attorney, 'O' = Other, Space = None.

Error Code	Field	Description
CR42	Claimant 2 Representative Last Name	If C2 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR43	Claimant 2 Representative First Name	If C2 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
CR44	Claimant 2 Representative Firm Name	If C2 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR45	Claimant 2 Representative TIN	May contain a 9-digit number, all zeroes or all spaces.
CR46	Claimant 2 Representative Mailing Address Line 1	Required if C2 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C2 Representative Indicator is equal to spaces, field must be equal to spaces. If C2 Representative State = 'FC', field must be equal to all spaces.
CR47	Claimant 2 Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR48	Claimant 2 Representative City	Required if C2 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C2 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C2 Representative State = 'FC', field must be equal to all spaces
CR49	Claimant 2 Representative State	If C2 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C2 Representative Indicator equal to spaces, field must be equal to spaces.
CR50	Claimant 2 Representative Zip	If C2 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C2 Representative Indicator equal to spaces, field must be equal to zeroes. If C2 Representative State = 'FC', field must be equal to all zeroes.
CR51	Claimant 2 Representative Zip+4	If C2 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C2 Representative Indicator equal to spaces, field must be equal to zeroes. If C2 Representative State = 'FC', field must be equal to all zeroes.

Error Code	Field	Description
CR52	Claimant 2 Representative Phone	If C2 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C2 Representative Indicator equal to spaces, field must be equal to zeroes. If C2 Representative State = 'FC', field must be equal to all zeroes.
CR53	Claimant 2 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C2 Representative Indicator equal to spaces, field must be equal to spaces.
CR54	Claimant 2 Representative Name/Firm Name	Either C2 Representative Last Name *and* C2 Representative First Name – or – C2 Representative Firm Name is required if C2 Representative Indicator is not equal to spaces.
CR61	Claimant 3 Representative Indicator	Must be an alpha value of: 'A' = Attorney, 'G' = Guardian, 'P' = Power of Attorney, 'O' = Other, Space = None.
CR62	Claimant 3 Representative Last Name	If C3 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR63	Claimant 3 Representative First Name	If C3 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
CR64	Claimant 3 Representative Firm Name	If C3 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR65	Claimant 3 Representative TIN	May contain a 9-digit number, all zeroes or all spaces.
CR66	Claimant 3 Representative Mailing Address Line 1	Required if C3 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C3 Representative Indicator is equal to spaces, field must be equal to spaces. If C3 Representative State = 'FC', field must be equal to all spaces.
CR67	Claimant 3 Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR68	Claimant 3 Representative City	Required if C3 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C3 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C3 Representative State = 'FC', field must be equal to all spaces

Error Code	Field	Description
CR69	Claimant 3 Representative State	If C3 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C3 Representative Indicator equal to spaces, field must be equal to spaces.
CR70	Claimant 3 Representative Zip	If C3 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C3 Representative Indicator equal to spaces, field must be equal to zeroes. If C3 Representative State = 'FC', field must be equal to all zeroes.
CR71	Claimant 3 Representative Zip+4	If C3 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C3 Representative Indicator equal to spaces, field must be equal to zeroes. If C3 Representative State = 'FC', field must be equal to all zeroes.
CR72	Claimant 3 Representative Phone	If C3 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C3 Representative Indicator equal to spaces, field must be equal to zeroes. If C3 Representative State = 'FC', field must be equal to all zeroes.
CR73	Claimant 3 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C3 Representative Indicator equal to spaces, field must be equal to spaces.
CR74	Claimant 3 Representative Name/Firm Name	Either C3 Representative Last Name *and* C3 Representative First Name – or – C3 Representative Firm Name is required if C3 Representative Indicator is not equal to spaces.
CR81	Claimant 4 Representative Indicator	Must be an alpha value of: 'A' = Attorney, 'G' = Guardian, 'P' = Power of Attorney, 'O' = Other, Space = None.
CR82	Claimant 4 Representative Last Name	If C4 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR83	Claimant 4 Representative First Name	If C4 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
CR84	Claimant 4 Representative Firm Name	If C4 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR85	Claimant 4 Representative TIN	May contain a 9-digit number, all zeroes or all spaces.

Error Code	Field	Description
CR86	Claimant 4 Representative Mailing Address Line 1	Required if C4 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C4 Representative Indicator is equal to spaces, field must be equal to spaces. If C4 Representative State = 'FC', field must be equal to all spaces.
CR87	Claimant 4 Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR88	Claimant 4 Representative City	Required if C4 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C4 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C4 Representative State = 'FC', field must be equal to all spaces
CR89	Claimant 4 Representative State	If C4 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C4 Representative Indicator equal to spaces, field must be equal to spaces.
CR90	Claimant 4 Representative Zip	If C4 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C4 Representative Indicator equal to spaces, field must be equal to zeroes. If C4 Representative State = 'FC', field must be equal to all zeroes.
CR91	Claimant 4 Representative Zip+4	If C4 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C4 Representative Indicator equal to spaces, field must be equal to zeroes. If C4 Representative State = 'FC', field must be equal to all zeroes.
CR92	Claimant 4 Representative Phone	If C4 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C4 Representative Indicator equal to spaces, field must be equal to zeroes. If C4 Representative State = 'FC', field must be equal to all zeroes.
CR93	Claimant 4 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C4 Representative Indicator equal to spaces, field must be equal to spaces.
CR94	Claimant 4 Representative Name/Firm Name	Either C4 Representative Last Name *and* C4 Representative First Name – or – C4 Representative Firm Name is required if C4 Representative Indicator is not equal to spaces.

Error Code	Field	Description
CT01	TPOC Date 2	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date). Required if a non-zero TPOC Amount 2 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be zero if TPOC Amount 2 is zero.
CT02	TPOC Amount 2	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 2 is supplied. Must be zero if TPOC Date 2 is zero.
CT03	Funding Delayed Beyond TPOC Start Date 2	Must contain a valid date or zeroes.
CT11	TPOC Date 3	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date). Required if a non-zero TPOC Amount 3 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be zero if TPOC Amount 3 is zero.
CT12	TPOC Amount 3	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 3 is supplied. Must be zero if TPOC Date 3 is zero.
CT13	Funding Delayed Beyond TPOC Start Date 3	Must contain a valid date or zeroes.
CT21	TPOC Date 4	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date). Required if a non-zero TPOC Amount 4 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be zero if TPOC Amount 4 is zero.
CT22	TPOC Amount 4	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 4 is supplied. Must be zero if TPOC Date 4 is zero.
CT23	Funding Delayed Beyond TPOC Start Date 4	Must contain a valid date or zeroes.
CT31	TPOC Date 5	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date). Required if a non-zero TPOC Amount 5 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be zero if TPOC Amount 5 is zero.
CT32	TPOC Amount 5	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 5 is supplied. Must be zero if TPOC Date 5 is zero.
CT33	Funding Delayed Beyond TPOC Start Date 5	Must contain a valid date or zeroes.

Error Code	Field	Description
SP31	Action Type	Record submitted prior to effective date of Medicare entitlement. Injured Party matched to a Medicare beneficiary. No correction necessary by RRE. Resubmit record in next quarterly file submission.
SP47	Action Type	No previously accepted record can be matched to submitted delete. Delete failed.
SP48	Action Type	No previously accepted record can be matched to submitted delete. Delete failed.
SP49	Action Type	No previously accepted record can be matched to submitted delete. Delete failed.
SP50	Action Type	Transaction attempted to add.update/delete an ORM record locked by the COBC. No changes are accepted via Section 111 reporting. Do NOT attempt to resubmit this record. See Section 12.2
TN99	TIN/Office Code	No matching, valid TIN Reference File Detail Record was found for the TIN/Office Code combination on the Claim Injput File Detail Record. Refer to errors returned on the TIN Reference Response File. Resubmit corrected TIN Reference File record and/or Claim Input File record.

APPENDIX E – ISO REGISTRATION FORMS & INSTRUCTIONS

ISOClaimSearch®

Medicare Secondary Payer Reporting Access Authorization Form - Instructions
Insurers, Self-Insureds, and PATs

Please use these Instructions when completing the ISO ClaimSearch Secondary Payer Reporting Access Authorization Form. Each number below corresponds with a numbered field on the Access Form.

Page 1 – Complete this page for each Responsible Reporting Entity (RRE) code your company obtains.

1. **Your Company's:** Name, Address, City, State, Zip, Phone, and Fax.
2. **CMS Account Manager:** The CMS account manager selected by your company – Name, Title, and E-mail.
3. **Member Type: Insurer** – Property/Casualty Insurers and Workers Comp I1nsurers
   Self Insured – Self Insurers and companies with self insured retentions

   PAT (Self Insured Pool) – Liability or Workers Compensation Self Insured Pools
4. **Company NAIC Code:** The National Association of Insurance Commissioners (NAIC) Code for your company (5 digits) – for insurers only.
5. **Office Reporting Code:** Your company's ISO ClaimSearch Office Reporting Code. If creating an RRE at the home office level, you will use a 4-character code. If creating an RRE at the office level, you will use a 9-character code.
6. **RRE Code:** A 9-digit Responsible Reporting Entity (RRE) code assigned to your company by CMS. If registering RREs at an office level only, please be sure each office that must report claims to CMS has an RRE code.
7. **RRE Description:** This is optional and used to identify the RRE – for example, line of business, department, claims system, etc.
8. **TIN/EIN:** Your company's Tax ID number included on the CMS registration for the RRE.
9. **Check Yes or No,** to indicate whether you want ISO to be your company's agent for performing monthly query files.
10. **CMS-Assigned Reporting Period:** The group number that is associated with the quarterly reporting period assigned by the CMS Coordination of Benefits Contractor (COBC) during the registration process.

CMS-Assigned Quarterly Reporting Date	1st Month	2nd Month	3rd Month
01 – 07	Group 1	Group 5	Group 9
08 – 14	Group 2	Group 6	Group 10
15 – 21	Group 3	Group 7	Group 11
22 – 28	Group 4	Group 8	Group 12

11. **Electronic Data Interchange Rep**: Name, Phone, and E-mail for the EDI representative assigned to the RRE during the registration process.
12. **Completed by**: Name and Title of the individual completing the form and the Date the form is completed.

Page 2 – Complete this page for each TIN/EIN and Site ID associated with the RRE that your company will report for. At least one Site ID is required. Also complete if your company requires additional office locations (Sites) for correspondence from CMS.

1. **TIN/EIN:** Your company's Tax ID Number included on the CMS registration for the RRE.
2. **RRE Code:** A 9-digit Responsible Reporting Entity (RRE) code assigned by CMS to your company for reporting claims to CMS.
3. **Site ID:** A 9-digit code developed by your company to identify office(s) that will receive correspondence from CMS.
4. **Site Name:** This is used to name the site – for example, line of business, department, claims system, etc. – and the site Address, City, State, and Zip.

Page 3 – Complete this page to provide existing ISO ClaimSearch User IDs for up to four personnel from your company that are authorized to download the monthly Medicare eligibility query results and the quarterly CMS acknowledgement and rejection files. If you need User IDs for new users, please contact ISO ClaimSearch Customer Support at 800-888-4476 or nisupport@iso.com.

1. **Your Company Name**
2. **Your Company's Office Reporting Code**: Your company's ISO ClaimSearch Office Reporting Code (4 characters).
3. **User Name:** The name of the authorized personnel that will have a User ID.
4. **User ID**: The ISO ClaimSearch User ID of your authorized personnel (5 characters).
5. **RRE Code**: The 9 digit RRE Code under which CMS reports will be posted. List the RRE Code(s) that each user will need access to view CMS reports. If there are more RREs for a user, please copy this page as necessary or provide all of the information on this page in a Microsoft® Excel spreadsheet with the additional RREs for the user.

ISO ClaimSearch®

Medicare Secondary Payer Reporting Access Authorization Form

Insurers, Self-Insureds, and PATs

Please complete the information below to set up access to the ISO ClaimSearch® Medicare Secondary Payer Reporting service. Please complete page 2 for each TIN/EIN and Site ID.

Each Responsible Reporting Entity (RRE) must complete this document.

Responsible Reporting Entity Information

1. Company Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

2. CMS Acct. Mgr.: _____

Title: _____ **E-mail:** _____

3. Member Type: ☐ **Insurer** ☐ **Self-Insured** ☐ **PAT (Self-Insured Pool)**

4. Company NAIC Code *(5 digits)* _____

5. Office Reporting Code *(Home Office is 4 characters and Office is 9 characters):* _____

6. RRE Code *(9 digits):* _____ **7. RRE Description:** _____

8. TIN/EIN *(9 digits):* _____

9. ISO will perform our monthly CMS Query File. **Yes** ☐ **No** ☐

10. CMS Assigned Reporting Period *(Group# as provided by CMS):*

1 ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ **11** ☐ **12** ☐

To identify your CMS assigned group number, please use the CMS defined group number that corresponds to the date your company has been designated to submit claims to CMS.

CMS-Assigned Quarterly Reporting Date	1st Month	2nd Month	3rd Month
01 - 07	Group 1	Group 5	Group 9
08 - 14	Group 2	Group 6	Group 10
15 - 21	Group 3	Group 7	Group 11
22 - 28	Group 4	Group 8	Group 12

11. Electronic Data Interchange Rep *(as provided by CMS):* _____

Phone: _____ **E-mail:** _____

12. Completed by Name: _____ **Title:** _____ **Date:** _____

Return form to: ISO ClaimSearch Customer Support at: Fax: 201-748-1472 or claimsearch.sales@iso.com. If you have any questions, please call 800-888-4476.

October 2009

ISO ClaimSearch®

Medicare Secondary Payer Reporting Access Authorization Form

Insurers, Self-Insureds, and PATs – Page 2

Please copy this form as necessary to provide Site ID information for each TIN/EIN.
At least one Site ID is required.

Required Information:

1. Company TIN/EIN *(9 digits):* _____ **2. RRE Code** *(9 digits):* _____

(Must be the same code as on page 1)

Site ID Information:

3. Site ID *(9 digits):* _____ **4. Site Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Site ID Information:

3. Site ID *(9 digits):* _____ **4. Site Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Site ID Information:

3. Site ID *(9 digits):* _____ **4. Site Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Return form to: ISO ClaimSearch Customer Support at: Fax: 201-748-1472 or claimsearch.sales@iso.com. If you have any questions, please call 800-888-4476.

ISO ClaimSearch®

Medicare Secondary Payer Reporting Access Authorization Form
Insurers, Self-Insureds, and PATs – Page 3

Provide existing ISO ClaimSearch User IDs for up to four personnel from your company who are authorized to download the monthly Medicare eligibility query results and the quarterly CMS acknowledgement and rejection files. If you need User IDs for new users, please contact ISO ClaimSearch Customer Support at 800-888-4476 or nisupport@iso.com.

1. Company Name: _____

2. Office Reporting Code *(4 characters):* _____

User ID Information

3. User Name: _____ **4. User ID** *(5 characters):* _____

5. RRE Code *(9 digits):* _____ **5. RRE Code** *(9 digits):* _____

5. RRE Code *(9 digits):* _____ **5. RRE Code** *(9 digits):* _____

User ID Information

3. User Name: _____ **4. User ID** *(5 characters):* _____

5. RRE Code *(9 digits):* _____ **5. RRE Code** *(9 digits):* _____

5. RRE Code *(9 digits):* _____ **5. RRE Code** *(9 digits):* _____

User ID Information

3. User Name: _____ **4. User ID** *(5 characters):* _____

5. RRE Code *(9 digits):* _____ **5. RRE Code** *(9 digits):* _____

5. RRE Code *(9 digits):* _____ **5. RRE Code** *(9 digits):* _____

User ID Information

3. User Name: _____ **4. User ID** *(5 characters):* _____

5. RRE Code *(9 digits):* _____ **5. RRE Code** *(9 digits):* _____

5. RRE Code *(9 digits):* _____ **5. RRE Code** *(9 digits):* _____

Return form to: ISO ClaimSearch Customer Support at: Fax: 201-748-1472 or claimsearch.sales@iso.com. If you have any questions, please call 800-888-4476.

ISO ClaimSearch®

Medicare Secondary Payer Reporting Access Authorization Form - Instructions
Third Party Administrators

The Access Authorization Form for third party administrators (TPAs) is in an Excel format. Please contact ISO ClaimSearch Customer Support at 800-888-4476 or claimsearch.sales@iso.com for the form. Please use these Instructions when completing the Access Authorization Form for TPAs.

Third Party Administrator Information

1. **Your Company's:** Name, Address 1, Address 2, City, State, Zip, Phone, Fax, Contact, Contact Title, Contact E-mail.
2. **Your Company's Office Reporting Code:** Your company's ISO ClaimSearch Office Reporting Code (4 characters).
3. **Completed by:** Name and Title of the individual completing the form and the Date the form is completed at your company.

Insurer or Self-Insured Company Information

4. **Company:** Name, Address 1, Address 2, City, State, Zip, Phone, and Fax.
5. **CMS Account Manager:** The CMS account manager selected by the company – Name, Title, and E-mail.
6. **Member Type:** **Insurer** – Property/Casualty insurers and Workers Comp insurers
   Self Insured – Self Insurers and companies with self insured retentions
   PAT (Self Insured Pool) – Liability or Workers Compensation Self Insured Pools
7. **Company NAIC Code:** The National Association of Insurance Commissioners (NAIC) Code for the company (5 digits) – for insurers only.
8. **Office Reporting Code:** The company's ISO ClaimSearch Office Reporting Code if known. If creating an RRE at the home office level, you will use a 4-character code. If creating an RRE at the office level, you will use a 9-character code.
9. **RRE Code:** A 9-digit Responsible Reporting Entity (RRE) code assigned to the company by CMS. If registering RREs at an office level only, please be sure each office that must report claims to CMS has an RRE code.
10. **RRE Description:** This is optional and used to identify the RRE – for example, line of business, department, claims system, etc.
11. **TIN/EIN:** The company's Tax ID number included on the CMS registration for the RRE.
12. **Will ISO Perform Monthly Query Yes or No:** Enter Y or N to indicate whether you want ISO to be the company's agent for performing monthly query files.
13. **CMS-Assigned Reporting Period:** The group number that is associated with the quarterly reporting period assigned by the CMS Coordination of Benefits Contractor (COBC) during the registration process.

CMS-Assigned Quarterly Reporting Date	1st Month	2nd Month	3rd Month
01 – 07	Group 1	Group 5	Group 9
08 – 14	Group 2	Group 6	Group 10
15 – 21	Group 3	Group 7	Group 11
22 – 28	Group 4	Group 8	Group 12

14. **CMS Electronic Data Interchange Rep**: Name, Phone, and E-mail for the EDI representative assigned to the RRE during the registration process.
15. **RRE Code:** A 9-digit Responsible Reporting Entity (RRE) code assigned by CMS to the company for reporting claims to CMS.
16. **Site ID:** A 9-digit code developed by the company to identify office(s) that will receive correspondence from CMS. At least one Site ID is required per TIN.
17. **Site Name:** This is used to name office locations (sites) that will need correspondence from CMS – for example, line of business, department, claims system, etc. Also needed are the Site Address, City, State, and Zip.
18. **User Name:** The name of the authorized personnel that will have a User ID. Maximum of four personnel from your company who are authorized to download the monthly Medicare eligibility query results and the quarterly CMS acknowledgement and rejection files. If you need User IDs for new users, please contact ISO ClaimSearch Customer Support at 800-888-4476 or nisupport@iso.com.
19. **User ID**: The ISO ClaimSearch User ID of your authorized personnel (5 characters) listed in #18 above. If an RRE has multiple User IDs that need access to download the reports, then list the multiple IDs one cell under each other, then start a new line for the next RRE.

APPENDIX F - MAPPING OF ISO UNIVERSAL FORMAT (UF) AND XML FIELDS TO THE CMS DETAIL RECORD LAYOUT

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
	CLAIM INPUT FILE HEADER RECORD		
	Will be pre-populated by ISO to default value 'NGCH'	RECORD IDENTIFIER	1
	Will be pre-populated by ISO for each file sent to the COBC.	SECTION 111 REPORTER ID	2
	Will be pre-populated by ISO to default value 'NGHPCLM'	SECTION 111 REPORTING FILE TYPE	3
	Will be pre-populated by ISO with the date the file was transmitted to the COBC.	FILE SUBMISSION DATE	4
	Will be pre-populated with spaces.	RESERVED FOR FUTURE USE.	5
	CLAIM INPUT FILE DETAIL RECORD		
RRE CODE UA01 465-473 ClaimsOccurrence/ com.iso_RRECd	If a group/company/office only registers one RRE, the company will provide it once upon registration with ISO and will not need to send this field on input; it will be derived by ISO. If a group/company/office registers more than one RRE, the company will provide the codes upon registration with ISO, but will also need to send this field on each claim so ISO will know which RRE code each claim belongs to. TPAs reporting under their own code always need to populate this field.	This is an ISO requirement; not a CMS requirement.	
	Will be pre-populated by ISO to default value 'NGCD'	RECORD IDENTIFIER	1
	Will be pre-populated by ISO with a unique identifier for each record sent.	DCN	2

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
	Will be pre-populated by ISO. • For ORM claims -will be sent as an "Add" when ISO receives the Medicare Eligible Indicator. • Will be sent as "Update" when the following fields are updated on the claim (CMS Date of Incident, Plan Insurance Type, ORM Indicator, ICD-9 Code, , TIN, TPOC Date, TPOC Amount, Claimant Information fields). • Will be sent as "Delete" and then again as "Add" when key fields change (CMS Date of Incident, Plan Insurance Type and ORM Indicator. • Will be sent as "Update" for the last time when the ORM Termination Date is sent. • For TPOC claims – will be sent as an "Add" when ISO receives both the Medicare Eligible Indicator and 1st TPOC date. • Will be sent as an "Update" when additional TPOCs are added or when there are changes in the TPOC amount. • ClaimSearch has added an indicator in which customers can request the deletion of a claimant from CMS.	ACTION TYPE	3

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
INJURED PARTY HICN UEX1 76-87 ClaimInvestigationAddRq/com.iso_SIUParty/com.iso_HICN	Once you are provided with a HICN on a query result file, you must add the HICN to your claim so it can be reported on future submissions to CMS.	INJURED PARTY HICN	4
SSN UO01 93-101 ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxId		INJURED PARTY SSN	5
LAST NAME UO01 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		INJURED PARTY LAST NAME	6
FIRST NAME UO01 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		INJURED PARTY FIRST NAME	7
MIDDLE NAME UO01 64-83 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/OtherGivenName		INJURED PARTY MIDDLE INIT	8
GENDER UO01 92 ClaimsParty/PersonInfo/GenderCd	CMS accepts a gender of "unknown". If no gender is reported, ISO will pass "0" for unknown.	INJURED PARTY GENDER	9
DOB UO01 84-91 ClaimsParty/PersonInfo/BirthDt		INJURED PARTY DOB	10
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	11
CMS DATE OF INCIDENT UEX3 11-18 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/com.iso_CMSIncidentDt		CMS DATE OF INCIDENT	12
DATE OF LOSS UA01 103-110 ClaimsOccurrence/LossDt		INDUSTRY DATE	13
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	14

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS UEX3 500-504 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_CauseOfInjuryCd (codelistref = "CauseOfInjuryCd")	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. DO NOT REPORT THE DECIMAL CODE IN THIS FIELD. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS	15
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	16
STATE OF VENUE UEX3 19-20 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ Addr/StateProvCd		STATE OF VENUE	17
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	18
ICD-9 CODE 1 UEX3 184-189 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd or UC01 272-277 ClaimsParty/ClaimsInjuredInfo/ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 1	19
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	20
ICD-9 CODE 2 UEX3 190-195 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd or UC01 278-283 ClaimsParty/ClaimsInjuredInfo/ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 2	21
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	22

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 3 UEX3 196-201 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd or UC01 284-289 ClaimsParty/ClaimsInjuredInfo/ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 3	23
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	24
ICD-9 CODE 4 UEX3 202-207 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd or UC01 290-295 ClaimsParty/ClaimsInjuredInfo/ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 4	25
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	26
ICD-9 CODE 5 UEX3 208-213 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd or UC01 296-301 ClaimsParty/ClaimsInjuredInfo/ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 5	27
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	28

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 6 UEX3 214-219 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 6	29
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	30
ICD-9 CODE7 UEX3 220-225 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 7	31
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	32
ICD-9 CODE 8 UEX3 226-231 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 8	33
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	34

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 9 UEX3 232-237 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 9	35
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	36
ICD-9 CODE 10 UEX3 238-243 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 10	37
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	38
ICD-9 CODE 11 UEX3 244-249 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 11	39
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	40

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 12 UEX3 250-255 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 12	41
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	42
ICD-9 CODE 13 UEX3 256-261 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. . Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 13	43
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	44
ICD-9 CODE 14 UEX3 262-267 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 14	45
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	46

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 15 UEX3 268-273 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 15	47
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	48
ICD-9 CODE 16 UEX3 274-279 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. . Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 16	49
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	50
ICD-9 CODE 17 UEX3 280-285 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. . Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 17	51
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	52

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ICD-9 CODE 18 UEX3 286-291 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. . Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. . If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 18	53
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	54
ICD-9 CODE 19 UEX3 292-297 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/ ICDDiagnosticCd	See Appendix H of the CMS User Guide version 3.1 for excluded codes. Also see ClaimSearch User Manuals and Guides for a spreadsheet containing valid codes. ISO will strip the decimal if the ICD-9 is reported to ISO with the decimal. If the code is less than 5 bytes, ISO will add spaces to the end as required by CMS.	ICD-9 DIAGNOSIS CODE 19	55
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	56
ALLEGED INJURIES/PROPERTY DAMAGE UC01 108-157 ClaimsParty/ClaimsInjuredInfo/ClaimsInjury/InjuryNatureDesc **OR** UEX3 450-499 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/ InjuryNatureDesc	This field will not be sent to CMS after 12/31/10, but you should still populate this field on your ClaimSearch reports because this is still a ClaimSearch required field.	DESCRIPTION OF ILLNESS/INJURY	57
PRODUCT LIABILITY INDICATOR UEX4 11 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo2/ com.iso_ProdLiabInd	This field is currently not being passed to CMS based on a change in CMS requirements.	PRODUCT LIABILITY INDICATOR	58

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
PRODUCT GENERIC NAME UEX4 12-51 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo2/ com.iso_GenName	This field is currently not being passed to CMS based on a change in CMS requirements.	PRODUCT GENERIC NAME	59
PRODUCT BRAND NAME UEX4 52-91 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo2/ com.iso_BrandName	This field is currently not being passed to CMS based on a change in CMS requirements.	PRODUCT BRAND NAME	60
PRODUCT MANUFACTURER UEX4 92-131 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo2/ com.iso_ProdMfr	This field is currently not being passed to CMS based on a change in CMS requirements.	PRODUCT MANUFACTURER	61
PRODUCT ALLEGED HARM UEX4 132-331 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo2/ com.iso_AllegedHarm	This field is currently not being passed to CMS based on a change in CMS requirements.	PRODUCT ALLEGED HARM	62
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	63
SELF-INSURED INDICATOR UA01 464 ClaimsOccurrence/com.iso_SelfInsuredInd	Will be pre-populated by ISO with "Y" for all member types of "Self Insured" or "Self Insured Pool" and with "N" for all P&C member types. TPAs reporting under their own ISO reporting code will need to populate this field. For all no-fault claims, the value will be defaulted to "N".	SELF INSURED INDICATOR	64
	ISO will pre-populate this field with "O" for Other than Individual. For all no-fault claims, the value will be defaulted to space.	SELF-INSURED TYPE	65
	This field is required if Self-Insured Type = I, but since ISO will always send "O," this field is not applicable.	POLICYHOLDER LAST NAME	66
	This field is required if Self-Insured Type = I, but since ISO will always send "O," this field is not applicable.	POLICYHOLDER FIRST NAME	67
	This field is required if Self-Insured Type = O and if Legal Name is not provided. Legal Name will always be provided so this field is not applicable.	DBA NAME	68
INSURED NAME UO01 14-83 ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName	This field is required if Self-Insured Type = O and DBA Name is not provided. ISO will pre-populate with the Insured Name.	LEGAL NAME	69

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	70
	ISO will pre-populate this field based on the policy/coverage/loss fields provided. (See Appendix A for table of mappings)	PLAN INSURANCE TYPE	71
TIN UA01 474-482 ClaimsOccurrence/TaxIdentity/TaxId	If an RRE only registers one TIN, the company will provide it once upon registration with ISO and will not need to send this field on input; it will be derived by ISO. If an RRE registers more than one TIN, the company will provide the TINS upon registration with ISO, but will also need to send this field on each claim so ISO will know which TIN each claim belongs to. TPAs reporting under their own code always need to populate this field.	TIN	72
SITE ID UA01 483-491 ClaimsOccurrence/com.iso_SiteId	If a TIN only registers one SITE ID, the company will provide it once upon registration with ISO and will not need to send this field on input; it will be derived by ISO. If a TIN registers more than one SITE ID, the company will provide the SITE IDs upon registration with ISO, but will also need to send this field on each claim so ISO will know which SITE ID each claim belongs to. TPAs reporting under their own code always need to populate this field. This is a numeric only field.	OFFICE CODE/SITE ID	73
POLICY NUMBER UA01 21-50 Policy/PolicyNumber		POLICY NUMBER	74
CLAIM NUMBER UA01 73-102 ClaimsOccurrence/ItemIdInfo/InsurerId		CLAIM NUMBER	75
	This field is Optional and will not be sent to CMS.	PLAN CONTACT DEPARTMENT NAME	76
	This field is Optional and will not be sent to CMS.	PLAN CONTACT LAST NAME	77
	This field is Optional and will not be sent to CMS.	PLAN CONTACT FIRST NAME	78
	This field is Optional and will not be sent to CMS.	PLAN CONTACT PHONE	79
	This field is Optional and will not be sent to CMS.	PLAN CONTACT PHONE EXTENSION	80
NO FAULT INSURANCE LIMIT UEX3 21-31 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_NFLTLimit	Fill with all 9's if there is no dollar limit. Fill with all 0's for WC or Liability claims.	NO-FAULT INSURANCE LIMIT	81

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
EXHAUST DATE FOR DOLLAR LIMIT FOR NO FAULT INSURANCE UEX3 32-39 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/com.iso_ExhaustDt		EXHAUST DATE FOR DOLLAR LIMIT FOR NO-FAULT INSURANCE	82
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	83
INJURED PARTY'S ATTORNEY OR OTHER REPRESENTATIVE INFORMATION			
ROLE IN THE CLAIM USP1 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd (codelistref="ClaimsPartyRoleCd)	All lawyer roles (Claimant Lawyer -LC, Insured Lawyer- LI, Law Office Manager-LM, Law Office-LO, Paralegal- LR, Lawyer-Other- LW, Lawyer for CMS Claimant - LS) will be mapped to A = Attorney. Guardian-GU will be mapped to G = Guardian/Conservator Power of Attorney-PW will be mapped to P = Power of Attorney. Other-OR will be mapped to O = Other Since CMS will only accept one representative, if more than one representative is reported, ISO will use the following hierarchy: Attorney, Guardian, Power of Attorney, Other. ISO will only send representatives that have all required fields reported.	INJURED PARTY REPRESENTATIVE INDICATOR	84
LAST NAME USP1 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname	If the business is reported as an AKA of the service provider, the AKA record would be sent to CMS as the business.	REPRESENTATIVE LAST NAME	85
FIRST NAME USP1 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName	If the business is reported as an AKA of the service provider, the AKA record would be sent to CMS as the business	REPRESENTATIVE FIRST NAME	86
BUSINESS NAME USP1 14-83 ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName	If the individual name is reported as an AKA of the service provider, the AKA record would be sent to CMS as the individual name.	REPRESENTATIVE FIRM NAME	87
TIN USP1 93-101 for SSN, 102-110 for TIN ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxId		REPRESENTATIVE TIN	88

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ADDRESS INFORMATION LINE 1 USP1 148-197 ClaimsParty/GeneralPartyInfo/Addr/Addr1		REPRESENTATIVE MAILING ADDRESS LINE 1	89
ADDRESS INFORMATION LINE 2 USP1 198-247 ClaimsParty/GeneralPartyInfo/Addr/Addr2		REPRESENTATIVE MAILING ADDRESS LINE 2	90
CITY USP1 248-272 ClaimsParty/GeneralPartyInfo/Addr/City		REPRESENTATIVE CITY	91
STATE USP1 273-274 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd	When reporting to ISO, if the Universal Format country field is "US" or blank, ISO will pass the US state to CMS. If the country field contains anything other than "US" or blank, ISO will pass "FC" for "foreign country" to CMS in the state field.	REPRESENTATIVE STATE	92
POSTAL CODE USP1 275-279 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		REPRESENTATIVE MAIL ZIP CODE	93
POSTAL CODE USP1 280-283 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		REPRESENTATIVE MAIL ZIP + 4	94
BUSINESS TELEPHONE USP1 297-306 ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo/PhoneTypeCd="Phone"CommunicationUseCd="Business"and PhoneNumber		REPRESENTATIVE PHONE	95
	This field is Optional and will not be sent to CMS.	REPRESENTATIVE PHONE EXTENSION	96
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	97
SETTLEMENT, JUDGMENT, AWARD OR OTHER PAYMENT INFORMATION			
ON-GOING RESPONSIBILITY FOR MEDICALS (ORM) INDICATOR UEX3 40 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/com.iso_ORMInd	This field is required on all claims to be sent to CMS even if you do not have on-going responsibility. Enter "Yes" if you do have ORM and "No" if you do not. This field is not used to determine if your claim will be sent to CMS according to the ORM or TPOC rules. ISO uses policy, coverage and loss type to map your claim to ORM or TPOC.	ORM INDICATOR	98

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
ON-GOING RESPONSIBILITY FOR MEDICALS (ORM) TERMINATION DATE UEX3 41-48 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_ORMDt		ORM TERMINATION DATE	99
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) DATE 1 UEX3 49-56 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCDt		TPOC DATE	100
TOTAL PAYMENT OBLIGA TION TO THE CLAIMANT (TPOC) AMOUNT 1 UEX3 57-67 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCAmt		TPOC AMOUNT	101
FUNDING DELAYED BEYOND TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) START DATE 1 UEX3 68-75 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCStartDt		FUNDING DELAYED BEYOND TPOC START DATE	102
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	103

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
	CLAIMANT INFORMATION 1		
ROLE IN THE CLAIM UACL 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	ES – Estate, FA – Family Member, OC – Other Claimant. If the Individual fields are used, ISO will map to E (Estate, Individual), F (Family, Individual) or O (Other, Individual) when sending to CMS. If the Business field is used, ISO will map to X (Estate, Entity Name), Y (Family, Entity Name) or Z (Other, Entity Name) when sending to CMS. If an invalid role is reported, ISO will default the role to OC.	CLAIMANT 1 RELATIONSHIP	104
UACL 223-231 for SSN, 232-240 for TIN ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxID	If the Individual fields are used, ISO will send the SSN. If the business field is used, ISO will send the TIN.	CLAIMANT 1 TIN	105
UACL 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		CLAIMANT 1 LAST NAME	106
UACL 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		CLAIMANT 1 FIRST NAME	107
UACL 64-83 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/OtherGivenName		CLAIMANT 1 MIDDLE INITIAL	108
UACL 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		CLAIMANT 1 ENTITY/ORGANIZATION NAME	109
UACL 84-133 ClaimsParty/GeneralPartyInfo/Addr/Addr1		CLAIMANT 1 MAILING ADDRESS LINE 1	110
UACL 134-183 ClaimsParty/GeneralPartyInfo/Addr/Addr2		CLAIMANT 1 MAILING ADDRESS LINE 2	111
UACL184-208 ClaimsParty/GeneralPartyInfo/Addr/City		CLAIMANT 1 CITY	112
UACL 209-210 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		CLAIMANT 1 STATE	113
UACL 211-215 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 1 ZIP	114
UACL 216-219 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 1 ZIP+4	115

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
UACL 241-250 ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		CLAIMANT 1 PHONE	116
	This field is Optional and will not be sent to CMS	CLAIMANT 1 PHONE EXTENSION	117
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	118
CLAIMANT 1 ATTORNEY/OTHER REPRESENTATIVE INFORMATION ***This information will be pulled from the Service Provider Record if the USP1 record follows the UACL record.***			
USP1 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	All lawyer roles (Claimant Lawyer -LC, Insured Lawyer- LI, Law Office Manager-LM, Law Office-LO, Paralegal- LR, Lawyer-Other- LW, Lawyer for CMS Claimant - LS) will be mapped to A = Attorney. Guardian-GU will be mapped to G = Guardian/Conservator Power of Attorney-PW will be mapped to P = Power of Attorney. Other-OR will be mapped to O = Other Since CMS will only accept one representative, if more than one representative is reported, ISO will use the following hierarchy: Attorney, Guardian, Power of Attorney, Other. ISO will only send representatives that have all required fields reported.	CLAIMANT 1 (C1) REPRESENTATIVE INDICATOR	119
USP1 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		C1 REPRESENTATIVE LAST NAME	120
USP1 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		C1 REPRESENTATIVE FIRST NAME	121
USP1 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		C1 REPRESENTATIVE FIRM NAME	122
USP1 93-101 for SSN, 102-110 for TIN. ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxId		C1 REPRESENTATIVE TIN	123
USP1 148-197 ClaimsParty/GeneralPartyInfo/Addr/Addr1		C1 REPRESENTATIVE MAILING ADDRESS 1	124

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
USP1 198-247 ClaimsParty/GeneralPartyInfo/Addr/Addr2		C1 REPRESENTATIVE MAILING ADDRESS 2	125
USP1 248-272 ClaimsParty/GeneralPartyInfo/Addr/City		C1 REPRESENTATIVE CITY	126
USP1 273-274 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		C1 REPRESENTATIVE STATE	127
USP1 275-279 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C1 REPRESENTATIVE ZIP	128
USP1 280-283 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C1 REPRESENTATIVE ZIP+4	129
USP1 287-296 if Individual, 297-306 if Business ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		C1 REPRESENTATIVE PHONE	130
	This field is Optional and will not be sent to CMS	C1 REPRESENTATIVE PHONE EXTENSION	131
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	132
CLAIMANT AUXILIARY RECORD *This record is being created by ISO for additional TPOC information and for additional claimants.*			
	Will be pre-populated by ISO to default value "NGCE"	RECORD IDENTIFIER	1
	Will be pre-populated by ISO with a unique identifier for each record sent.	DCN	2
INJURED PARTY HICN UEX1 76-87 ClaimInvestigationAddRq/com.iso_SIUParty/com.iso_HICN		INJURED PARTY HICN	3
SSN UO01 93-101 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		INJURED PARTY SSN	4
LAST NAME UO01 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		INJURED PARTY LAST NAME	5
FIRST NAME UO01 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		INJURED PARTY FIRST NAME	6

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
	CLAIMANT 2 INFORMATION		
ROLE IN THE CLAIM UACL 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	ES – Estate, FA – Family Member, OC – Other Claimant. If the Individual fields are used, ISO will map to E (Estate, Individual), F (Family, Individual) or O (Other, Individual) when sending to CMS. If the Business field is used, ISO will map to X (Estate, Entity Name), Y (Family, Entity Name) or Z (Other, Entity Name) when sending to CMS. If an invalid role is reported, ISO will default the role to OC.	CLAIMANT 2 RELATIONSHIP	7
UACL 223-231 for SSN, 232-240 for TIN ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxID	If the Individual fields are used, ISO will send the SSN. If the business field is used, ISO will send the TIN.	CLAIMANT 2 TIN	8
UACL 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		CLAIMANT 2 LAST NAME	9
UACL 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		CLAIMANT 2 FIRST NAME	10
UACL 64-83 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/OtherGivenName		CLAIMANT 2 MIDDLE INITIAL	11
UACL 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		CLAIMANT 2 ENTITY/ORGANIZATION NAME	12
UACL 84-133 ClaimsParty/GeneralPartyInfo/Addr/Addr1		CLAIMANT 2 MAILING ADDRESS LINE 1	13
UACL 134-183 ClaimsParty/GeneralPartyInfo/Addr/Addr2		CLAIMANT 2 MAILING ADDRESS LINE 2	14
UACL184-208 ClaimsParty/GeneralPartyInfo/Addr/City		CLAIMANT 2 CITY	15
UACL 209-210 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		CLAIMANT 2 STATE	16
UACL 211-215 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 2 ZIP	17
UACL 216-219 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 2 ZIP + 4	18

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
UACL 241-250 ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		CLAIMANT 2 PHONE	19
	This field is Optional and will not be sent to CMS	CLAIMANT 2 PHONE EXTENSION	20
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	21
CLAIMANT 2 ATTORNEY/OTHER REPRESENTATIVE INFORMATION			
USP1 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	All lawyer roles (Claimant Lawyer -LC, Insured Lawyer- LI, Law Office Manager-LM, Law Office-LO, Paralegal- LR, Lawyer-Other- LW, Lawyer for CMS Claimant - LS) will be mapped to A = Attorney. Guardian-GU will be mapped to G = Guardian/Conservator Power of Attorney-PW will be mapped to P = Power of Attorney. Other-OR will be mapped to O = Other Since CMS will only accept one representative, if more than one representative is reported, ISO will use the following hierarchy: Attorney, Guardian, Power of Attorney, Other. ISO will only send representatives that have all required fields reported.	CLAIMANT 2 (C2) REPRESENTATIVE INDICATOR	22
USP1 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		C2 REPRESENTATIVE LAST NAME	23
USP1 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		C2 REPRESENTATIVE FIRST NAME	24
USP1 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		C2 REPRESENTATIVE FIRM NAME	25
USP1 93-101 for SSN, 102-110 for TIN. ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxId		C2 REPRESENTATIVE TIN	26
USP1 148-197 ClaimsParty/GeneralPartyInfo/Addr/Addr1		C2 REPRESENTATIVE MAILING ADDRESS LINE 1	27

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
USP1 198-247 ClaimsParty/GeneralPartyInfo/Addr/Addr2		C2 REPRESENTATIVE MAILING ADDRESS LINE 2	28
USP1 248-272 ClaimsParty/GeneralPartyInfo/Addr/City		C2 REPRESENTATIVE CITY	29
USP1 273-274 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		C2 REPRESENTATIVE STATE	30
USP1 275-279 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C2 REPRESENTATIVE ZIP	31
USP1 280-283 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C2 REPRESENTATIVE ZIP + 4	32
USP1 287-296 if Individual, 297-306 if Business ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		C2 REPRESENTATIVE PHONE	33
	This field is Optional and will not be sent to CMS	C2 REPRESENTATIVE PHONE EXTENSION	34
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	35
CLAIMANT 3 INFORMATION			
ROLE IN THE CLAIM UACL 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	ES – Estate, FA – Family Member, OC – Other Claimant. If the Individual fields are used, ISO will map to E (Estate, Individual), F (Family, Individual) or O (Other, Individual) when sending to CMS. If the Business field is used, ISO will map to X (Estate, Entity Name), Y (Family, Entity Name) or Z (Other, Entity Name) when sending to CMS. If an invalid role is reported, ISO will default the role to OC.	CLAIMANT 3 (C3) RELATIONAHIP	36
UACL 223-231 for SSN, 232-240 for TIN ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxID	If the Individual fields are used, ISO will send the SSN. If the business field is used, ISO will send the TIN.	CLAIMANT 3 TIN	37
UACL 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		CLAIMANT 3 LAST NAME	38
UACL 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		CLAIMANT 3 FIRST NAME	39
UACL 64-83 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/OtherGivenName		CLAIMANT 3 MIDDLE INITIAL	40

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
UACL 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		CLAIMANT 3 ENTITY/ORGANIZATION NAME	41
UACL 84-133 ClaimsParty/GeneralPartyInfo/Addr/Addr1		CLAIMANT 3 MAILING ADDRESS LINE 1	42
UACL 134-183 ClaimsParty/GeneralPartyInfo/Addr/Addr2		CLAIMANT 3 MAILING ADDRESS LINE 2	43
UACL184-208 ClaimsParty/GeneralPartyInfo/Addr/City		CLAIMANT 3 CITY	44
UACL 209-210 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		CLAIMANT 3 STATE	45
UACL 211-215 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 3 ZIP	46
UACL 216-219 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 3 ZIP + 4	47
UACL 241-250 ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		CLAIMANT 3 PHONE	48
	This field is Optional and will not be sent to CMS	CLAIMANT 3 PHONE EXTENSION	49
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	50
CLAIMANT 3 ATTORNEYREPRESENATATIVE INFORMATION			
USP1 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	All lawyer roles (Claimant Lawyer -LC, Insured Lawyer- LI, Law Office Manager-LM, Law Office-LO, Paralegal- LR, Lawyer-Other- LW, Lawyer for CMS Claimant - LS) will be mapped to A = Attorney. Guardian-GU will be mapped to G = Guardian/Conservator Power of Attorney-PW will be mapped to P = Power of Attorney. Other-OR will be mapped to O = Other. Since CMS will only accept one representative, if more than one representative is reported, ISO will use the following hierarchy: Attorney, Guardian, Power of Attorney, Other. ISO will only send representatives that have all required fields reported.	CLAIMANT 3 (C3) REPRESENTATIVE INDICATOR	51

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
USP1 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		C3 REPRESENTATIVE LAST NAME	52
USP1 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		C3 REPRESENTATIVE FIRST NAME	53
ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	**COMMENTS**	**CMS FIELD**	**CMS FIELD #**
USP1 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		C3 REPRESENTATIVE FIRM NAME	54
USP1 93-101 for SSN, 102-110 for TIN. ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxId		C3 REPRESENTATIVE TIN	55
USP1 148-197 ClaimsParty/GeneralPartyInfo/Addr/Addr1		C3 REPRESENTATIVE MAILING ADDRESS LINE 1	56
USP1 198-247 ClaimsParty/GeneralPartyInfo/Addr/Addr2		C3 REPRESENTATIVE MAILING ADDRESS LINE 2	57
USP1 248-272 ClaimsParty/GeneralPartyInfo/Addr/City		C3 REPRESENTATIVE CITY	58
USP1 273-274 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		C3 REPRESENTATIVE STATE	59
USP1 275-279 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C3 REPRESENTATIVE ZIP	60
USP1 280-283 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C3 REPRESENTATIVE ZIP + 4	61
USP1 287-296 if Individual, 297-306 if Business ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		C3 REPRESENTATIVE PHONE	62
	This field is Optional and will not be sent to CMS	C3 REPRESENTATIVE PHONE EXTENSION	63
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	64

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
	CLAIMANT 4 INFORMATION		
ROLE IN THE CLAIM UACL 11-12 ClaimsParty/ClaimsPartyInfo/ClaimsPartyRoleCd	ES – Estate, FA – Family Member, OC – Other Claimant. If the Individual fields are used, ISO will map to E (Estate, Individual), F (Family, Individual) or O (Other, Individual) when sending to CMS. If the Business field is used, ISO will map to X (Estate, Entity Name), Y (Family, Entity Name) or Z (Other, Entity Name) when sending to CMS. If an invalid role is reported, ISO will default the role to OC.	CLAIMANT 4 (C4) RELATIONAHIP	65
UACL 223-231 for SSN, 232-240 for TIN ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxID	If the Individual fields are used, ISO will send the SSN. If the business field is used, ISO will send the TIN.	CLAIMANT 4 TIN	66
UACL 14-43 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/Surname		CLAIMANT 4 LAST NAME	67
UACL 44-63 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/GivenName		CLAIMANT 4 FIRST NAME	68
UACL 64-83 ClaimsParty/GeneralPartyInfo/NameInfo/PersonName/OtherGivenName		CLAIMANT 4 MIDDLE INITIAL	69
UACL 14-83 with Business Indicator ClaimsParty/GeneralPartyInfo/NameInfo/CommlName/CommercialName		CLAIMANT 4 ENTITY/ORGANIZATION NAME	70
UACL 84-133 ClaimsParty/GeneralPartyInfo/Addr/Addr1		CLAIMANT 4 MAILING ADDRESS LINE 1	71
UACL 134-183 ClaimsParty/GeneralPartyInfo/Addr/Addr2		CLAIMANT 4 MAILING ADDRESS LINE 2	72
UACL184-208 ClaimsParty/GeneralPartyInfo/Addr/City		CLAIMANT 4 CITY	73
UACL 209-210 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		CLAIMANT 4 STATE	74
UACL 211-215 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		CLAIMANT 4 ZIP	75

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
UACL 216-219 ClaimsParty/GeneralPartyI nfo/Addr/PostalCode		CLAIMANT 4 ZIP + 4	76
UACL 241-250 ClaimsParty/GeneralPartyI nfo/Communications/Phon eInfo		CLAIMANT 4 PHONE	77
	This field is Optional and will not be sent to CMS	CLAIMANT 4 PHONE EXTENSION	78
	Will be pre-populated by ISO with spaces	RESERVED FOR FUTURE USE	79
CLAIMANT 4 ATTORNEY/REPRESENTATIVE INFORMATION			
USP1 11-12 ClaimsParty/ClaimsPartyIn fo/ClaimsPartyRoleCd	All lawyer roles (Claimant Lawyer -LC, Insured Lawyer- LI, Law Office Manager- LM, Law Office-LO, Paralegal- LR, Lawyer-Other- LW, Lawyer for CMS Claimant - LS) will be mapped to A = Attorney. Guardian-GU will be mapped to G = Guardian/Conservator Power of Attorney-PW will be mapped to P = Power of Attorney. Other-OR will be mapped to O = Other Since CMS will only accept one representative, if more than one representative is reported, ISO will use the following hierarchy: Attorney, Guardian, Power of Attorney, Other. ISO will only send representatives that have all required fields reported.	CLAIMANT 4 (C4) REPRESENTATIVE INDICATOR	80
USP1 14-43 ClaimsParty/GeneralPartyI nfo/NameInfo/PersonNam e/Surname		C4 REPRESENTATIVE LAST NAME	81
USP1 44-63 ClaimsParty/GeneralPartyI nfo/NameInfo/PersonNam e/GivenName		C4 REPRESENTATIVE FIRST NAME	82
USP1 14-83 with Business Indica ClaimsParty/GeneralPartyI nfo/NameInfo/CommiNam e/CommercialName tor		C4 REPRESENTATIVE FIRM NAME	83

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
USP1 93-101 for SSN, 102-110 for TIN. ClaimsParty/GeneralPartyInfo/NameInfo/TaxIdentity/TaxID		C4 REPRESENTATIVE TIN	84
USP1 148-197 ClaimsParty/GeneralPartyInfo/Addr/Addr1		C4 REPRESENTATIVE MAILING ADDRESS LINE 1	85
USP1 198-247 ClaimsParty/GeneralPartyInfo/Addr/Addr2		C4 REPRESENTATIVE MAILING ADDRESS LINE 2	86
USP1 248-272 ClaimsParty/GeneralPartyInfo/Addr/City		C4 REPRESENTATIVE CITY	87
USP1 273-274 ClaimsParty/GeneralPartyInfo/Addr/StateProvCd		C4 REPRESENTATIVE STATE	88
USP1 275-279 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C4 REPRESENTATIVE ZIP	89
USP1 280-283 ClaimsParty/GeneralPartyInfo/Addr/PostalCode		C4 REPRESENTATIVE ZIP + 4	90
USP1 287-296 if Individual, 297-306 if Business ClaimsParty/GeneralPartyInfo/Communications/PhoneInfo		C4 REPRESENTATIVE PHONE	91
	This field is Optional and will not be sent to CMS	C4 REPRESENTATIVE PHONE EXTENSION	92
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) DATE 2 UEX3 76-83 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/com.iso_TPOCDt		TPOC DATE 2	93
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) AMOUNT 2 UEX3 84-94 ClaimInvestigationAddRq/com.iso_AddCovInfo/com.iso_CovInfo1/com.iso_TPOCAmt		TPOC AMOUNT 2	94

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
FUNDING DELAYED BEYOND TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) START DATE 2 UEX3 95-102 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCStartDt		FUNDING DELAYED BEYOND TPOC START DATE 2	95
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) DATE 3 UEX3 103-110 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCDt		TPOC DATE 3	96
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) AMOUNT 3 UEX3 111-121 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCAmt		TPOC AMOUNT 3	97
FUNDING DELAYED BEYOND TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) START DATE 3 UEX3 122-129 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCStartDt		FUNDING DELAYED BEYONE TPOC START DATE 3	98
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) DATE 4 UEX3 130-137 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCDt		TPOC DATE 4	99

ISO FIELD UF RECORD TYPE & POSITION XML LOCATION	COMMENTS	CMS FIELD	CMS FIELD #
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) AMOUNT 4 UEX3 138-148 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCAmt		TPOC AMOUNT 4	100
FUNDING DELAYED BEYOND TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) START DATE 4 UEX3 149-156 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCStartDt		FUNDING DELAYED BEYOND TPOC START DATE 4	101
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) DATE 5 UEX3 157-164 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCDt		TPOC DATE 5	102
TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) AMOUNT 5 UEX3 165-175 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCAmt		TPOC AMOUNT 5	103
FUNDING DELAYED BEYOND TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) START DATE 5 UEX3 176-183 ClaimInvestigationAddRq/ com.iso_AddCovInfo/com.iso_CovInfo1/ com.iso_TPOCStartDt		FUNDING DELAYED BEYOND TPOC START DATE 5	104
	Will be pre-populated by ISO with spaces.	RESERVED FOR FUTURE USE	105

APPENDIX G - PRE-QUERY EXTRACT FILE LAYOUT

Each unique claimant/coverage will be provided on a separate line.

Position	Field Name	Length	Type	Description
THE FIELDS BELOW WILL BE PROVIDED BY ISO TO THE CUSTOMER				
1-11	ClaimSearch Identifier	11	A/N	A unique identifier created by ISO for every claim on the database.
12-41	Claim Number	30	A/N	Claim Number as reported to ISO ClaimSearch
42-45	Company Code	4	A/N	The first 4 characters of the customer ID code assigned by ISO ClaimSearch
46-50	Office Code	5	A/N	The last 5 digits of the customer ID code assigned by ISO ClaimSearch
51-80	Policy Number	30	A/N	Policy Number as reported to ISO ClaimSearch
81-90	Date of Loss	10	N	YYYY-MM-DD
91-94	Policy Type	4	A/N	Found in Appendix A of the Universal Format Manual
95-103	Person Number	9	A/N	This is a unique identifier created by ISO for every involved party on the database.
104-107	Coverage Type	4	A/N	Found in Appendix A of the Universal Format Manual
108-111	Loss Type	4	A/N	Found in Appendix A of the Universal Format Manual
112-141	Last Name	30	A/N	Claimant's Last Name
142-166	First Name	25	A/N	Claimant's First Name
167-176	Date of Birth	10	N	YYYY-MM-DD
177	Gender	1	A/N	M = Male F = Female U= Unknown Blank Field = Unknown
178-186	Social Security Number	9	N	SSN as reported to ISO ClaimSearch
187-189	Claim Status	3	A/N	O = Open C = Closed CWP = Closed without Payment
190-199	Claim Closed Date	10	N	YYYY-MM-DD
200	Universal Format or Legacy Indicator	1	A/N	U = Universal Format Claim L – Legacy Claim
201	CMS-Applicable Claim Type	1	A/N	Y = the type of claim is applicable for CMS. N = the type of claim is not applicable for CMS.
202	Run Type	1	A/N	For ISO Internal Use

Position	Field Name	Length	Type	Description
THE FIELDS BELOW MAY BE RETURNED TO ISO FOR ADDITION TO ISO's QUERY TABLE				
203-211	Applied COBC Assigned Section 111 Reporter ID (RRE Code)	9	A/N	COBC Assigned Section 111 Reporter ID for this claim. If the RRE Code you are assigned is less than 9 digits, please place zeros before the ID. EX: 000012345
212-220	Applied Social Security Number	9		SSN to be used for the query
221-230	Applied Date of Birth	10		Date of birth to be used for the query
231	Applied Gender	1		Gender to be used for the query, M = Male F = Female
232	Applied Open/Closed Indicator	3		O = Open C = Closed CWP = Closed without Payment
233-242	Applied Closed Date	10		YYYY-MM-DD Date Claim Closed

APPENDIX H – ICD-9 AND CAUSE OF INJURY, INCIDENT, OR ILLNESS CODE REPORTING TIPS

On every ADD or UPDATE claim submitted to CMS after January 1, 2011, at least one ICD-9-CM and one Alleged Cause of Injury, Incident or Illness Code is required.

Below are the requirements from CMS for ICD-9 codes:

- The ICD-9 code describes the alleged injury/illness. The CMS file layout has a 5 byte Alpha Numeric field for ICD-9 codes. In the file sent to CMS, the ICD-9 must be left justified and must include any leading zeros. The ICD-9 should be submitted with numeric values only. It should not include the decimal point. It should be space filled as needed on the right. It must be on one of the three most current lists/files of valid ICD-9 diagnosis codes accepted by CMS for Section 111 reporting found at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Codes must match ***exactly*** to one of the codes considered valid for Section 111. ***Partial matches are not accepted.*** See Section 11.2.5 of the CMS User Guide for more details. No "E" codes or "V" codes are permitted. The ICD-9 must not be on the list of Excluded ICD-9 Diagnosis codes found in Appendix H of the CMS User Manual. A code submitted for Section 111 reporting is not valid just because the NGHP RRE might have accepted the code on a medical claim submitted to them.

Reporting ICD-9 codes through ISO ClaimSearch:

- The Universal Format file layout and ClaimSearch website has a 6 byte field for ICD-9 codes vs. the 5 byte field accepted by CMS. ISO will handle left justifying the ICD-9 codes sent to CMS, but ISO cannot add any leading zeros to the ICD-9. If a valid ICD-9 code has leading zeros, you must enter the zeros. In ClaimSearch, if you enter the decimal point, ISO will strip it prior to sending to CMS. If you do not enter the decimal point, it is also fine. If the valid ICD-9 code which you enter is less than 5 bytes, ISO will add the spaces to the right of the code to meet CMS' requirements.

Below are the requirements from CMS for Alleged Cause of Injury, Incident or Illness codes:

- The Alleged Cause of Injury, Incident or Illness code is the External Cause of Injury Code "E Code" describing the alleged cause of injury/illness. The CMS file layout has a 5 byte Alpha Numeric field for Cause of Injury codes. In the file sent to CMS, the Cause of Injury code must be left justified. The code must begin with the letter "E". It should not include the decimal point. It should be space filled as needed on the right. It must be on one of the three most current lists/files of valid ICD-9 diagnosis codes accepted by CMS for Section 111 reporting found at www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Codes must match ***exactly*** to one of the codes considered valid for Section 111. ***Partial matches are not accepted.*** See Section 11.2.5 of the CMS User Guide for more details. The Cause of Injury code must not be on the list of Excluded ICD-9 Diagnosis codes found in Appendix H of the CMS User Manual

Reporting Alleged Cause of Injury, Incident or Illness codes through ISO ClaimSearch:

- The Universal Format file layout and ClaimSearch website has a 5 byte field for Cause of Injury codes which is the same length as the CMS requirement. ISO will handle left justifying the Cause of Injury codes sent to CMS. You must enter the E in front of the numeric code; ISO will not add this for you. In ClaimSearch, since ISO only has a 5 byte field, **do not enter the decimal point because if you do, since some Cause of Injury codes are 5 bytes long, if you enter the**

decimal, the last digit could get dropped. If you do enter the decimal point, however, ISO will strip it prior to sending the file to CMS and will send the first 5 bytes reported. If the valid Cause of Injury code which you enter is less than 5 bytes, ISO will add the spaces to the right of the code to meet CMS' requirements.

ISO Tools to assist you with finding ICD-9 or Cause of Injury Codes

ICD-9 and Alleged Cause of Injury Valid List Spreadsheet

In order to assist you with finding ICD-9 or Cause of Injury Codes on the three most recent lists, ISO has published the lists on a spreadsheet on the Manuals & Resources section of the ClaimSearch website. The spreadsheet contains separate tabs for each of the three most current lists of valid ICD-9 and Cause of Injury codes. You should enter the codes into the system exactly as they appear on that list; codes must match exactly to the list. On the spreadsheet, ISO has highlighted in red the codes which are on the Excluded ICD-9 and Cause of Injury lists. You should not use any of those excluded codes.

ICD-9 and Alleged Cause of Injury ClaimSearch Website Look-Up Feature

If your company enters claims via the ClaimSearch website, ISO has added a look-up feature for ICD-9 and Cause of Injury codes which will allow you to enter a description of an injury or a cause of injury which will bring you to possible ICD-9 or Cause of Injury codes which are found on the three accepted CMS lists.

When using this tool, here are some tips:

1. The filter for determining the code type is removed if you delete the INJ or COI from the search field. Therefore, if you enter just the word "leg" and delete "INJ" or "COI" when searching on either, you receive codes for diagnosis and cause of injury regardless of which link you selected.

2. If you enter "left" or "right" in front of a keyword such as leg" nothing comes back, but if you enter "lower left leg" results are received. Solution - The inclusion of the word "left" is causing the issue.

   Because the CMS reportable codes have no actual LEFT/RIGHT in their descriptions, when you search on "Left leg" the search can't find codes which specifically refer to the "**left** leg". There are NO codes in there that mention LEFT or RIGHT they just refer to the "leg". If you search on "leg" only you will get results. When you search on "lower left leg", the search logic still can't find anything for "left" but rationalizes its search on a "2 out of 3" basis to use the words "lower" and "leg" which also of course yields some valid results. SUGGESTION: Do not enter the words "left or right" when searching for ICD9s on this link.

Additional Information

EXAMPLES of ICD-9 Codes:

1. 959 followed by 2 spaces is not a valid ICD-9 diagnosis code. It must be submitted with the additional digits/qualifiers after the 959, but with no decimal.

Valid choices are:

95901 Head injury, unspecified

95909 Injury of face and neck

95911 Other injury of chest wall

95912 Other injury of abdomen

95913 Fracture of corpus cavernosum

95914 Other injury of external genitals

95919 Other injury of other sites of trunk

2. On the CMS file, '037' should be submitted as '037', '038.3' should be submitted as '0383', '038.42'should be submitted as '03842'.

   When reporting to ISO ClaimSearch, '037' should be submitted as '037', '038.3' may be submitted as '038.3' or '0383', and '038.42' may be submitted as '03842' or '038.42'.

EXAMPLES OF ALLEGED CAUSE OF INJURY, INCIDENT or ILLNESS Codes

1. E885 followed by a space is not a valid Cause of Injury code. It must be submitted with an additional digit, but with no decimal.

Valid choices are:

E8850 Fall from (non-motorized) scooter

E8851 Fall from roller skates

E8852 Fall from skateboard

E8853 Fall from skis

E8854 Fall from snowboard

E8859 Fall from other slipping, tripping, or stumbling

2. On the CMS file, 'E812.0' should be submitted as 'E8120', 'E919.2' should be submitted as 'E9192', 'E956'should be submitted as 'E956'.

When reporting to ISO ClaimSearch, 'E812.0' should be submitted as 'E8120', 'E919.2' should be submitted as 'E9192', and 'E956' should be submitted as 'E956'.

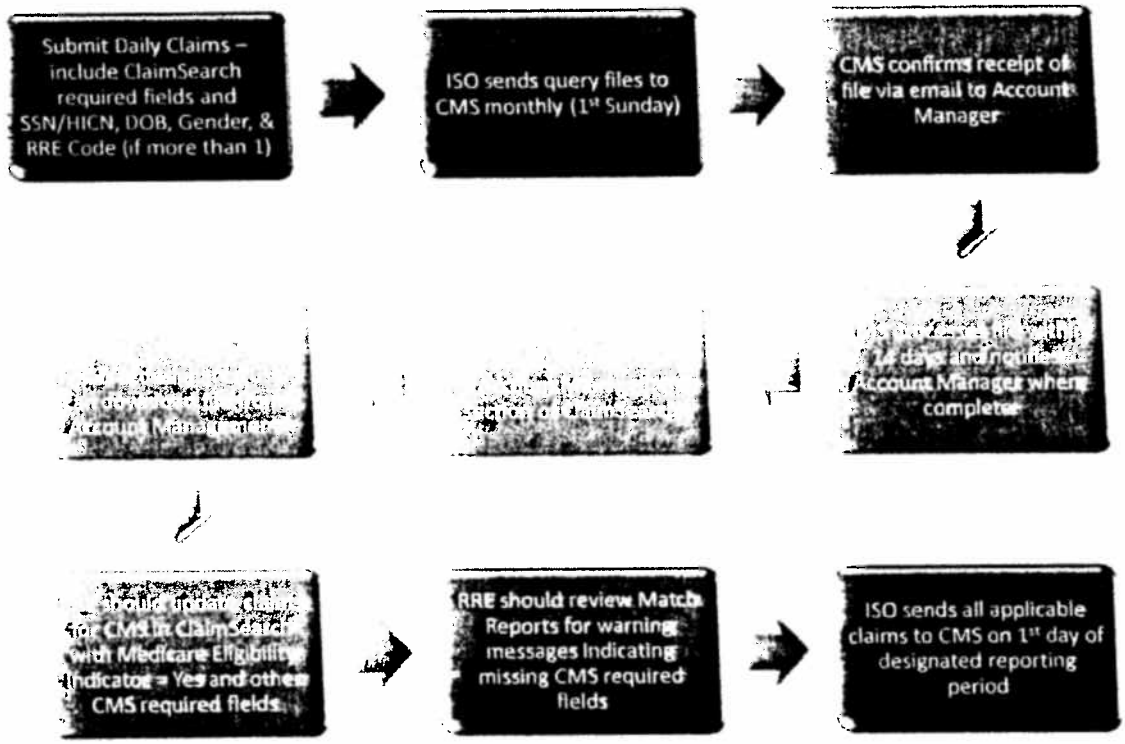
NOTE: Based on comments from a recent CMS Town Hall meeting, it is suggested not to use generic or vague diagnosis codes. If the codes used are vague, the claimant could be denied medical treatment if the recovery contractor is unable to determine the exact injury.

APPENDIX I – MEDICARE SECONDARY PAYER REPORTING SERVICE PROCESS OUTLINE

ISO ClaimSearch

Medicare Secondary Payer Reporting Service

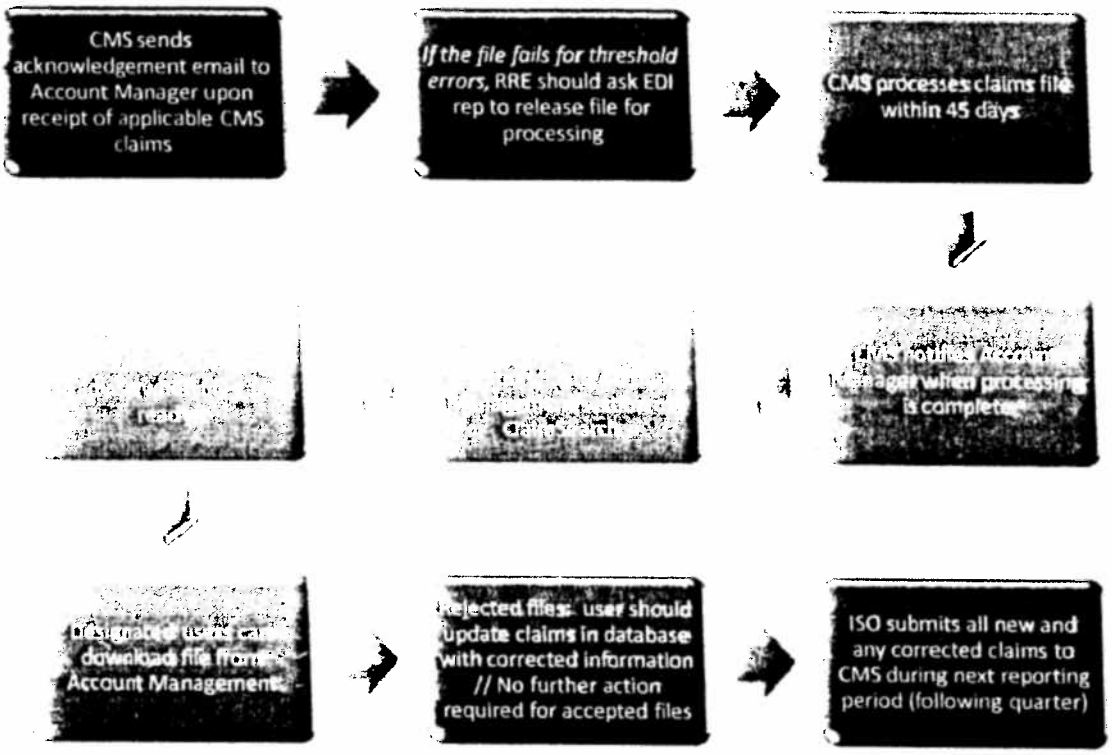
Process Outline



ISO ClaimSearch

Medicare Secondary Payer Reporting Service

Process Outline Continued



A10-0533

PRODUCT SUPPLEMENT

EXECUTED ORIGINAL

This is a Product Supplement to the ISO Master Agreement, 01/05 edition, dated September 22, 2009 by and between City of New Haven ("Licensee") and Insurance Services Office, Inc., on behalf of itself, its subsidiaries and affiliates, (all of which are collectively referred to herein as "ISO").

X MEDICARE SECONDARY PAYER REPORTING

This service forwards claims submitted by Licensee to the Department of Health and Human Services Center for Medicare and Medicaid Services (CMS) in compliance with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173), which imposed mandatory reporting requirements on liability, no-fault and workers compensation insurers. The legislation requires reporting of bodily injury claims filed by Medicare-eligible claimants to CMS.

The service performs reporting on behalf of the participant in compliance with the requirements and processes established by CMS. The participant may have one or more Registered Reporting Entities (RREs) as defined by CMS requirements. The participant must provide claims information meeting CMS requirements to ISO ClaimSearch.

The service also provides an error-correction process to allow the participant to correct any errors in claims they may have submitted that were rejected by CMS due to missing or inaccurate data.

ISO will also assist participants with a CMS-developed query process to help the participant determine which claimants are Medicare eligible.

Customers may also choose to participate in the separate, optional ISO ClaimSearch service, AppendDS℠ which can provide data to help the participant find information about claimants necessary to meet CMS data-reporting requirements (see AppendDS section below).

Additional Terms and Conditions Applicable to this Product:

1. Licensee hereby requests the Product(s) described herein and represents that this request is made by its authorized representative. Licensee warrants that it is in compliance with all terms of the Master Agreement between the parties. At Licensee's expense, Licensee shall provide all Licensee equipment and appropriate interfacing devices for any lines, modems and terminals compatible with the connectivity arrangement(s) selected and to pay for all costs to connect to an ISO-provided connect point or designated node, if necessary.

2. Licensee agrees that Licensee shall not reproduce, retransmit, republish, or otherwise transfer for any commercial purpose any information that Licensee receives from the Services, other than as permitted under this Product Supplement

Fee: **$4.85 per claim plus $200 Annual Participation Fee for each Required Reporting Entity (RRE):** If Licensee is an insurance company, the fee will be based on Licensee's direct written premium for the second preceding year for the Casualty line of business. If Licensee is not an insurance company, Licensee shall be invoiced monthly for each claimant submitted to CMS during the preceding month. The invoice will be based on the prices in effect at the effective date of this product supplement and the commencement date of each renewal period thereafter.

Product Supplement Term: July 1, 2010 – June 30, 2011
Term automatically renews for one-year periods unless terminated pursuant to the Master Agreement.

Except as provided herein or modified hereby, all terms, covenants and conditions of the Master Agreement remain unchanged. To the extent any provision in this Product Supplement conflicts with any similar provision in the Master Agreement, the terms set forth on this Product Supplement shall control. This Product Supplement may be executed in separate counterparts, each such counterpart being deemed to be an original instrument, and all such counterparts shall together constitute the same agreement

This Agreement is not valid against ISO unless and until executed by the appropriate ISO officer or authorized representative at the appropriate ISO home office.

☐ APPEND-DS

This service will find missing or omitted data, specifically, social security numbers and other information that the customer can append to its claim reports to complete them.

1. Licensee hereby requests the Product(s) described herein and represents that this request is made by its authorized representative. Licensee warrants that it is in compliance with all terms of the Master Agreement between the parties. At Licensee's expense, Licensee shall provide all Licensee equipment and appropriate interfacing devices; for any lines, modems and terminals compatible with the connectivity arrangement(s) selected and to pay for all costs to connect to an ISO-provided connect point or designated node, if necessary.

2. Licensee warrants that it is licensed to access an ISO ClaimSearch database. Licensee agrees that if its right to access the ISO ClaimSearch databases terminates that Licensee's right to access this Append DS Product shall also terminate.

3. Licensee accepts all information "AS IS." Licensee acknowledges and agrees that the data is obtained from third-party sources, which may or may not be completely thorough and accurate, and that Licensee shall not rely on the third-party data provider or ISO for the accuracy or completeness of information supplied.

4. Licensee warrants to the data providers and ISO that Licensee proceeds at its own risk in choosing to rely upon public records information in whole or in part. Licensee agrees that the data providers assume no responsibility for the accuracy of the information, errors that occur in the conversion of data or for Licensee's use of the information. Neither the third-party data providers, nor any third-party data provider to them (for purposes of indemnification, warranties and limitations on liability the third-party data providers and their data providers are hereby collectively referred to as third-party data providers), shall be liable to Licensee for any loss or injury arising out of or caused in whole or in part by third-party data providers' acts or omissions, whether negligent or otherwise, in procuring, compiling, collecting, interpreting, reporting, communicating, or delivering the Services. If, notwithstanding the foregoing, liability can be imposed on a provider, then Licensee agrees, that the aggregate liability for any and all losses or injuries arising out of any act or omission of a third-party data provider in connection with anything to be done or furnished under this agreement, regardless of the cause of the loss or injury shall never exceed $100.00 and Licensee agrees that it will not seek punitive damages in any suit against a third-party data provider. The third-party data providers do not make and hereby disclaim any warranty, express or implied with respect to the Services provided hereunder. The third-party data providers do not guarantee or warrant the correctness, completeness, merchantability, or fitness for a particular purpose of their Services or the components thereof or information provided hereunder. In no event shall a third-party data provider be liable for any direct, incidental or consequential damages, however arising, incurred by Licensee's receipt or use of information delivered hereunder, or the unavailability thereof.

5. Licensee agrees that Licensee shall not reproduce, retransmit, republish, or otherwise transfer for any commercial purpose any information that Licensee receives from the Services, other than as permitted under this Supplement. Licensee acknowledges that the third-party data providers shall retain all right, title, and interest in and to the data and information provided by the Services under applicable contractual, copyright, and related laws, and Licensee shall use such materials consistent with the third-party data providers' interests and notify them of any threatened or actual infringement of their rights.

6. Licensee warrants that it, its employees and authorized users of the ISO ClaimSearch Databases shall use its public records Services consistent with the privacy obligations and any other terms and provisions of the Gramm-Leach-Bliley Act (15 U.S.C. 6801 et seq.) ("GLB") or any similar state or local statute, rules and regulations, the Federal Drivers Privacy Protection Act (18 U.S.C. Section 2721 et seq.) ("DPPA") and similar state and local statutes, rules and regulations, and such legislation and rules and regulations as may be enacted or adopted after the date of this Agreement, by any federal, state or local government body. In addition, Licensee shall not use any information received from the public records Services for consumer credit purposes, consumer insurance underwriting, employment purposes, or for any other purpose covered by the federal Fair Credit Reporting Act (15 U.S.C. § 1681 et seq.) or similar state or local statute, rule, or regulation. Licensee shall abide by such legislation and rules and regulations as may be enacted or adopted after the date hereof.

7. Licensee hereby agrees that upon reasonable notice and at a mutually agreeable time, ISO may periodically audit Licensee's books and records relevant to the use of this public records Service in order to ensure compliance with the GLB and all other applicable laws. The third-party data providers shall also investigate all legitimate reports of abuse or misuse of their Services. Violations discovered in any review will be subject to immediate action including, but not limited to, termination of Licensee's right to use the public records Services, legal action, and/or referral to federal or state regulatory agencies.

Fee: **$ 0.35 per Transaction** **(plus applicable taxes)**
Licensee shall be invoiced monthly for each Append-DS transaction recorded for the applicable line of business during the preceding month. The invoice will be based on the prices in effect at the time of billing.

Product Supplement Term: July 1, 2010 – June 30, 2010
Term automatically renews for one-year periods unless terminated pursuant to the Master Agreement.

In witness whereof, the parties hereto have caused this product supplement to be executed by their duly authorized representatives.

Licensee: City of New Haven	ISO: INSURANCE SERVICES OFFICE, INC. On behalf of itself, its subsidiaries and affiliates.
Signature:	Signature: Richard Della Rocca
Print Name: John DeStefano, Jr.	Print Name: RICHARD DELLA ROCCA
Title: Mayor for City of New Haven	Title: VICE PRESIDENT ISO CLAIMS SOLUTIONS
Date:	Date: 7/12/10

☐Revised
MedicareSecondaryPayerRep.doc
April 2009 Ed.

APPROVED AS TO FORM
AND CORRECTNESS

Victor A. Bolden
Corporation Counsel

Date 6/28/10

MASTER AGREEMENT
January 2005 Edition

Agreement made this _____ day of _____, 200_9_ between Insurance Services Office, Inc., located at 545 Washington Boulevard, Jersey City, New Jersey 07310-1686, on behalf of itself, its subsidiaries and affiliates ("ISO®") and **City of New Haven** located at **165 Church Street, 4th Floor, New Haven, CT 06510** ("Licensee").

In consideration of the mutual covenants contained herein, the parties hereto agree as follows:

1. LICENSE: ISO grants to Licensee a non-exclusive, non-transferable license to use the data, products, information, services, ISO-supplied software and associated documentation ("Products") set forth in the Product Supplement(s) attached hereto and incorporated herein by reference, within the states, jurisdictions or territories of the United States of America, subject to the terms and conditions contained herein. "Agreement" shall mean this agreement, its Annexes, Exhibits and all Product Supplement(s) executed by Licensee. ISO will provide to Licensee, for sole use by Licensee, the Products described in the Product Supplement(s) provided the Licensee executes all necessary Product Supplements, and abides by the terms of this Agreement. Licensee shall use the Products solely to provide services to insurance companies that are licensed by ISO to receive and use the ISO Products for the state(s) and lines(s) of insurance or subdivision(s) thereof pertaining to the Products. Except as may be permitted under a Product Supplement(s), Licensee agrees to restrict access to all Products and the information or data therein to those employees of Licensee who have a need to use them solely in connection with the provision of the services noted above ("authorized employees"). Neither Licensee, its authorized employees, any other authorized user of the Products, nor anyone acting by or through Licensee shall sell, transfer, distribute, publish, disclose, display or otherwise make the Products available, in whole or in part, or any of the information or data therein, to any other person or entity, without the express written consent of ISO.

For the sole purpose of verifying Licensee's compliance with this Agreement, ISO may require, on at least ten (10) days prior notice, an examination and copying at ISO's expense of any and all books of account, records, documents and other materials under the control of the Licensee, and other related entities, which contain records of Licensee's use of the Products in accordance with this Agreement. All such documents shall be kept available by Licensee for at least three (3) years after the period to which they relate. ISO may exercise this right once in any twelve (12) month period. The audit will be conducted by ISO or its authorized representatives.

In the event Licensee fails to satisfy any of the conditions specified above, ISO may immediately cease providing Products to Licensee and may terminate access to the Products and thereafter notify Licensee of same.

2. TERM: This Agreement is effective on the date noted above and shall remain in force until terminated.

a. This Agreement or any Supplement may be terminated by ISO:

i. if Licensee materially violates any term or condition of this Agreement and fails to cure said violation within thirty (30) days following receipt of notice thereof from ISO. In such event, ISO may cease providing the Product(s) to Licensee. Upon Licensee curing its default hereunder to ISO's satisfaction, ISO may reinstitute the provision of and access to Products at the earliest reasonable opportunity; or

ii. if Licensee defaults in the payment of any fee(s) or charge(s) due upon ten (10) days prior notice.

iii. if ISO makes a business decision to discontinue any Product(s), and/or the maintenance and support of any Product(s) licensed hereunder, provided, however, that ISO shall provide Licensee with at least ninety (90) days notice of any such discontinuance; or

iv. immediately, if Licensee (i) terminates or suspends its business; (ii) becomes subject to any bankruptcy or insolvency proceeding under federal or state law; or (iii) becomes insolvent or becomes subject to direct control by a trustee, receiver or similar authority; or

v. for any other reason, upon one hundred eighty (180) days written notice to Licensee.

b. Licensee may terminate any Supplement, or portion thereof:

i. if ISO terminates or suspends its business; or

ii. if ISO becomes subject to any bankruptcy or insolvency proceeding under federal or state law; or

iii. if ISO becomes insolvent or becomes subject to direct control by a trustee, receiver or similar authority; or

iv. for any other reason, upon one hundred eighty (180) days written notice to ISO.

In the event of termination including expiration of this Agreement or any Supplement, ISO shall have the right to immediately cease providing Products to Licensee and immediately terminate Licensee's access to Products without notice or demand. Termination under this Section 2 shall not relieve Licensee of its obligations regarding property or copyright as specified in Sections 7. and 8. In the event of termination as a result of Licensee's failure to comply with any of its obligations under this Agreement, Licensee shall continue to be obligated for any payments due up to and including the effective date of termination. In addition, if the license to use any Product provided to Licensee electronically is terminated, Licensee will be liable and charged for payment of all termination or de-installation charges incurred by ISO related thereto, if any. Termination of this Agreement and/or any Product Supplement(s) shall be in addition to and not in lieu of any other remedies available to ISO. Upon the expiration or other termination of this Agreement, the Licensee shall immediately discontinue use of the Products, and at ISO's option, (i) return to ISO all applicable Products provided, including all manuals, associated documentation and any copies thereof; or (ii) destroy the applicable Products, including all manuals, associated documentation and any copies thereof, and certify in a writing signed by an officer of the Licensee that they have been so returned or destroyed.

3. RESTRICTION AGAINST TRANSFER OF CONFIDENTIAL INFORMATION: ISO and Licensee acknowledge that much, if not all, of the material and information which has or will come into their possession from the other party pursuant to this Agreement consists of confidential and proprietary information, nonpublic personal information or software of the disclosing party and its affiliates, agents, licensees or third parties ("Confidential Information"). The party receiving such Confidential Information agrees to hold it in strictest confidence and agrees not to release or disclose such Confidential Information to any individual or entity, whether employee, subcontractor, or subcontractor employee, except that the receiving party may disclose such information to its employees who are necessarily involved in the provision of the products and services hereunder and have agreed in writing to keep the information confidential to protect the disclosing party's interests.

a. The receiving party agrees that it shall not disclose or release any confidential, secret or proprietary information of the disclosing party or any information marked and/or designated as confidential by the disclosing party ("Confidential Information") which is disclosed to the receiving party either (i) in a writing or other tangible form or (ii) orally to any third party, except with the disclosing party's prior written consent, unless compelled to do so by legal process. In such case, the receiving party shall give the disclosing party reasonable and sufficient notice to allow the disclosing party to take action to protect its Confidential Information and trade secrets. The receiving party shall treat the disclosing party's Confidential Information in the same manner and with the same protections and safeguards as receiving party treats its own confidential information and trade secrets.

b. The party receiving Confidential Information further agrees not to (i) use the Confidential Information for its own benefit or for the benefit of any third parties, other than for the performance of its obligations under this Agreement, and (ii) release or disclose the Confidential Information to any other entity, either during the term or after the termination of this Agreement. In the event of any breach of this confidentiality obligation or of the obligations relative to the rights to products and services pursuant to this Agreement, or any product developed or delivered in providing services, the party receiving the Confidential Information acknowledges that the disclosing party would have no adequate remedy at law, since the harm caused by such a breach could not be easily measured and compensated for in the form of damages.

c. The party receiving the Confidential Information shall be solely responsible for maintaining the security of such Confidential Information and for complying with all federal, state, provincial and local laws, regulations, or other requirements including the Gramm-Leach-Bliley Act of 1999, 15 U.S.C., Section 6801, et seq. as amended from time to time governing the privacy, confidentiality and non-disclosure of such information.

d. The foregoing obligations shall not apply to any information which: a) is or becomes known publicly through no fault of the receiving party; or b) is acquired or learned by the receiving party from a third party entitled to disclose it; or c) is already known to the receiving party before receipt from the disclosing party as shown by the receiving party's written records; or d) is independently developed by the receiving party, as shown by the receiving party's written records; or e) must be disclosed by operation of law.

e. The foregoing obligations of each party shall survive the termination or expiration of this Agreement.

4. RESTRICTION AGAINST COPYING OR MODIFYING THE LICENSED PRODUCT: The Products licensed hereunder may not be copied, modified or reproduced except as provided herein unless compelled to do so by legal process. In such case, Licensee shall give ISO reasonable and sufficient notice to allow ISO to take action to protect its confidential information and trade secrets. Use of the Products does not confer the right to print, reprint, publish, copy, sell, file or use same in any manner without the written permission of the copyright owner. Licensee agrees to reproduce and incorporate ISO's copyright notice, or the third party copyright notice stated in the Products, in any copies, modifications or partial copies of the Products that Licensee makes.

5 FEES: Licensee agrees to pay all fees invoiced for Products licensed to Licensee by ISO regardless of whether Licensee actually uses any or all such Products. Licensee agrees to pay such invoices within thirty (30) days of receipt of the invoice. The fee for the initial distribution term for each Product licensed after the effective date of the Agreement is indicated on the applicable Product Supplement. ISO reserves the right to amend the fees due on prior notice to Licensee. Except for taxes based on ISO's income, Licensee shall be responsible to pay for all federal, state, and local sales, excise, use or similar taxes in connection with Licensee's license or use of the Products licensed hereunder. Interest shall be due on all charges not paid within thirty (30) days at the rate of 1% per month or the maximum interest permitted by law, whichever is less. A default in the payment of charges due for one Product may result in the termination of the license to use all Products and termination of access to Products provided to Licensee electronically. In the event Licensee desires to re-establish its license to use and/or access the Products after ISO has terminated this Agreement hereunder, and ISO agrees to provide such Products or access, Licensee shall pay all outstanding charges, as well as any administrative costs that ISO may impose, and all charges incurred by ISO in disconnecting and reconnecting Licensee access to the Products, if applicable. For any Products which will be provided to Licensee electronically, the Licensee, at its expense is required to: (a) provide all necessary Licensee equipment and appropriate interfacing devices, and (b) pay for all costs to connect to an ISO-provided connect point or designated node.

6. SECURITY REQUIREMENTS: a. Licensee agrees to comply with the following security requirements for any Products licensed hereunder. Licensee agrees that it will not attempt to circumvent any security measures contained within or associated with any Product licensed hereunder. Licensee shall not attempt to decompile, reverse engineer, or otherwise disassemble or obtain the source code of any Product provided hereunder.

b. To the extent a Product licensed hereunder is accessed electronically, the following security measures will apply. Third-party software, sometimes called "spyware", can infect a user's computer and capture data without permission. ISO is not responsible if any confidential data of Licensee or its agents is compromised in this manner. In order to protect its own data, ISO reserves the right, without prior notice, to suspend access to any ISO web application by any user or agent whose computer is infected in this manner until the infection is removed. ISO will make reasonable efforts to notify the Licensee beforehand, but circumstances may require prompt action.

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11. NOTICE: Unless otherwise provided in this Agreement, all notices, directions, instructions, orders, requests, demands, acknowledgments and other communications required or permitted to be given hereunder shall be in writing, addressed to the parties at their respective addresses set forth at the beginning of this Agreement or to such other addresses as one party may furnish in writing to the other, and shall be deemed properly given or made when: (i) delivered personally; (ii) made or given by prepaid telex, telegraph, facsimile or telecopier; or (iii) received by first class mail, postage prepaid, or upon the expiration of three (3) days after any such notice, direction, instruction, order, request, demand, acknowledgment or other communication is deposited in the United States mail for transmission by first class mail, postage prepaid, whichever shall occur first.

12. SURVIVAL OF TERMS: The terms and conditions set forth in Sections 2 through 4, and 6 through 14 shall survive the termination of this Agreement, except as may be provided in the provisions themselves.

13. CHOICE OF LAW AND EXCLUSIVE JURISDICTION AND VENUE FOR ADJUDICATING ANY DISPUTE: This Agreement shall be governed by and construed in accordance with the laws of the State of New York as an agreement made and wholly performed therein. Any litigation, action, or proceeding arising out of any dispute concerning or otherwise attempting to enforce, interpret, or remedy any breach of this Agreement shall be brought only in a court of competent jurisdiction (whether federal or state) sitting within the State and County of New York. The parties irrevocably and unconditionally (a) submit to personal jurisdiction in the State of New York and consent to venue in the County of New York with respect to any such action, (b) waive any objection to the jurisdiction and venue in the State and County of New York, and (c) agree not to plead or claim in any such court that any such suit, action or proceeding has been brought in an inconvenient forum.

14. COUNTERPARTS. This Agreement may be executed in separate counterparts, each such counterpart being deemed to be an original instrument, and all such counterparts shall together constitute the same agreement

15. GENERAL: This Agreement, its Annexes, Exhibits and Product Supplement(s), constitutes a fully integrated contract and states the entire Agreement between the parties. It supersedes and merges any and all prior discussions, representations, demonstrations, negotiations, correspondence, writings and other agreements and together states the entire understanding and agreement upon which ISO and Licensee rely respecting the subject matter of this Agreement. The captions or headings used in this Agreement are for convenience and in no way define, limit or enlarge the scope of this Agreement or any of its Sections. This Agreement, and the Annexes and Product Supplements, may be changed or modified only in writing signed by authorized representatives of both parties. If any provision of this Agreement is determined to be invalid under any applicable statute or rule of law, it is, to the extent invalid, deemed to be omitted and the remaining provisions of the Agreement shall continue in full force and effect. The failure or delay of either party to insist upon the performance of any of the terms of this Agreement in any one or more instances will not be construed as a waiver or relinquishment of the future performance of any such term, and the obligation of the parties with respect to any such future performance will continue in full force and effect. No action, regardless of form, arising out of this Agreement may be brought by Licensee more than one year after the cause of action has arisen. This Agreement inures to the benefit of and is binding upon the successors and assigns of ISO and may be assigned by ISO to any of its subsidiaries, affiliates, or related companies. It likewise inures to the benefit of Licensee, but no interest herein shall be transferred or assigned in any manner by Licensee.

This contract is not valid against ISO unless and until executed by the appropriate ISO officer or authorized representative at the appropriate ISO home office.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement by their authorized representatives as of the day and year first above written.

CITY OF NEW HAVE LICENSEE	INSURANCE SERVICES OFFICE, INC. on behalf of itself, its subsidiaries and affiliates(ISO)
Signed: _____	Signed: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

January 2005 Edition Master Agreement .doc

From: "ISO ClaimSearch MSP" <claimsearchmsp@iso.com>
To: <ppernal@newhavenct.net>
Date: 9/19/2013 9:02 AM
Subject: MMSEA Section 111 Bulletin: Summary of CMS Changes

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MMSEA Section 111 Bulletin:
Summary of CMS Changes

To help with your claims reporting for the ISO ClaimSearch® Medicare Secondary Payer Reporting Service, here's a summary of changes affecting CMS reporting.

TPOC THRESHOLD REDUCED

For TPOCs dated on or after October 1, 2013, the reporting threshold for Liability and Workers' Compensation will be reduced to $2,000 (from the current $5,000). The primary effect of this change is that you will likely see more reportable claims. Please modify your processes to begin sending all TPOCs above $2000 as of 10/1/13. The minimum threshold remains at $300; TPOCs below $300 will be rejected by CMS.

CAUSE OF INJURY and NON-MEDICARE BENEFICIARY RECOMMENDATIONS

With the recent change from CMS to make the Cause of Injury code ("E-Code") and identification of the payee in the event of death of the claimant (Non-Medicare Beneficiary) optional, ISO ClaimSearch will continue to allow you to report this optional information to CMS. However, to prevent unnecessary CMS rejections for optional fields, this information will be validated by ISO ClaimSearch and will only be reported to CMS if the information reported in these fields is valid.

ICD-10 PREPARATION

Effective with dates of injury beginning October 1, 2014, CMS will require ICD-10 diagnosis codes, replacing the current ICD-9 codes used for Section 111 reporting. Because these codes are supplied by the provider community, if you enter claims via the ISO ClaimSearch website, your changes should be minimal. For example, you'll be able the enter ICD-10 codes received or looked up through the ISO ClaimSearch look-up tool or spreadsheets of valid codes. If you enter claims through system-to-system reporting, your claims systems must be capable of recording and forwarding ICD-10 codes. ISO ClaimSearch will be fully prepared for this change in the test environment early in the 4th quarter of 2013. Changes will include the addition of the new ICD-10 diagnosis and Cause of Injury codes on the ISO ClaimSearch website and in the record layouts for system-to-system companies, an updated lookup table and spreadsheet to include ICD-10 codes in addition to the current ICD-9 capability, and new warning messages to alert you when you have entered an invalid code. (Diagnosis coding for pre-10/1/2014 injuries can continue to utilize ICD-9 codes indefinitely.) CMS has announced a 6-month grace period before the ICD-10 requirement will be enforced and ISO ClaimSearch will incorporate this rule as well. Additional detailed information will be provided later this year with updates as the 2014 implementation date approaches.

We will continue to monitor these changes and provide updates as needed. For more information, please contact the ISO Customer Support Center at 1-800-888-4476 or at ClaimSearchMSP@iso.com.

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From: "ISO ClaimSearch MSP" <ClaimSearchMSP@iso.com>
To: <ppernal@newhavenct.net>
Date: 6/26/2013 2:59 PM
Subject: MMSEA Section 111 Bulletin: June 11th ICD-10 Alert

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MMSEA Section 111 Bulletin:
June 11th ICD-10 Alert

On June 11, 2013 the Centers for Medicare & Medicaid Services (CMS) released an Alert regarding the plan to integrate ICD-10 codes into Section 111 reporting, while phasing out the use of ICD-9 codes. The following items contained in the Alert merit notice by ISO ClaimSearch and ISO Crowe Paradis customers:

- ICD-10 data will be required in phases – CMS announced that ICD-10 codes will only be required for injuries occurring on or after April 1, 2015. ICD-10 codes will be required for medical providers as of October 1, 2014. It is important to emphasize that ICD-10 codes will only be required for injuries occurring on or after April 1, 2015. This means that ICD-10 data will not be required for claims that are reported for nearly two years.

- ICD-9 codes will be accepted indefinitely – For injuries occurring prior to April 1, 2015, CMS will continue to accept ICD-9 codes. The Section 111 reporting record layout will be modified to create an indicator allowing a reporting agent or RRE to note whether reported codes are either ICD-9 or ICD-10.

- No simultaneous reporting – CMS' record layout will not support simultaneous reporting of ICD-9 and ICD-10 codes on the same reported claim. For claims with dates of injury occurring prior to April 1, 2015, RREs will need to report with either ICD-9 or ICD-10 codes but not both.

- CMS will not accept ICD-10 codes until October 1, 2014 – Providers will be required to use ICD-10 codes as of October 1, 2014. CMS will not accept ICD-10 on production claim input files until that same date – October 1, 2014. Until that date, RREs should only utilize ICD-9 codes.

We will continue to monitor these changes and provide updates, including updates specific to your program, if and as required. For more information, please contact the ISO Customer Support Center at 1-800-888-4476 or at ClaimSearchMSP@iso.com <mailto:ClaimSearchMSP@iso.com>, or contact your ISO Crowe Paradis representative or email mspnavigator@cpscmsa.com <mailto:mspnavigator@cpscmsa.com>.

ISO and ISO Crowe Paradis are members of the Verisk Insurance Solutions group at Verisk Analytics. For more information, visit www.iso.com <http://www.iso.com?elq=ea42771418fd4a918ae9401b2763f92b&elqCampaignId=678> and www.cpscmsa.com <http://www.cpscmsa.com?elq=ea42771418fd4a918ae9401b2763f92b&elqCampaignId=678>.

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From: "Centers for Medicare & Medicaid Services" <cmslists@subscriptions.cms.hhs.gov>
To: <ppernal@newhavenct.net>
Date: 6/27/2013 10:24 AM
Subject: The ICD-10 Deadline is October 1, 2014

News Updates | June 27, 2013

The ICD-10 Deadline is October 1, 2014

The compliance deadline for ICD-10 is *October 1, 2014*. CMS Administrator Marilyn Tavenner has affirmed the ICD-10 deadline* *and encourages providers, payers, and vendors across the health care industry to prepare to use the new codes for services provided on or after October 1, 2014.

The CMS website [http://www.cms.gov/ICD10] offers a variety of resources targeted to payers [http://cms.gov/Medicare/Coding/ICD10/Payer_Resources.html], providers [http://cms.gov/Medicare/Coding/ICD10/ProviderResources.html], vendors [http://cms.gov/Medicare/Coding/ICD10/Vendor_Resources.html], and others to help you with your transition to ICD-10. Timelines, checklists, fact sheets, and in-depth guides are all available to help you and your organization plan for a smooth transition.

Keep Up to Date on ICD-10
Visit the CMS ICD-10 website [http://www.cms.gov/ICD10] for the latest news and resources to help you prepare for the *October 1, 2014*, deadline.

Department of Health and Human Services [http://hhs.gov] Centers for Medicare & Medicaid Services [http://www.cms.gov]

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ISO ClaimSearch® Medicare Secondary Payer Section 111 update

The Centers for Medicare and Medicaid Services (CMS) has released service enhancements and new training materials. As a result, ISO has made some modifications to the ISO ClaimSearch® Medicare Secondary Payer Reporting Service.

Training materials

To assist responsible reporting entities (RRE) in registering and reporting, CMS recently released its latest user guide, version 3.3, for reporting claims on Medicare-eligible claimants in compliance with the MMSEA Section 111 requirements and the *CMS Quick Reference Guide.*

Extension of reporting limit

CMS is now providing a voluntary extension of the reporting limit for liability TPOCs (total payment obligation to the claimant). The amounts of the extensions decrease over time, as reflected below:

TPOC reporting extension amount	TPOC dates	Minimum liability TPOC amount (threshold)	Begin reporting
$100,000 and above	10/1/11 – 3/31/12	$5,000	1st quarter 2012
$50,000 – 99,999	4/1/12 – 6/30/12	$5,000	3rd quarter 2012
$25,000 – 49,999	7/1/12 – 9/30/12	$5,000	4th quarter 2012
$5,000 – 24,999	10/1/12 – 12/31/12	$5,000	1st quarter 2013
$2,000 – 4,999	1/1/13 – 12/31/13	$2,000	2nd quarter 2013
$600 – 1,999	1/1/14 – 12/31/14	$600	2nd quarter 2014
$0 – 599	1/1/15 – indefinite	$0	2nd quarter 2015

ISO ClaimSearch Medicare Secondary Payer Reporting Service participants have the option of reporting only claims above the voluntary extension or reporting without the extension, in which case, the minimum threshold (currently $5,000) would apply.

Profile report verification process

Effective January 1, 2012, CMS initiated a profile report verification process requiring all RREs to verify the information in their profile reports and advise CMS of any changes within ten days. Failure to respond could result in deactivation from CMS reporting. In addition, ISO ClaimSearch Medicare Secondary Payer Reporting Service participants should notify ISO of any changes to their profiles so that we can keep our records current.

We recently released *ISO ClaimSearch Medicare Secondary Payer Reporting Service User Guide* version 3.6. Updates include recent CMS reporting service enhancements and other important ISO ClaimSearch Medicare Secondary Payer Reporting Service improvements outlined in the Summary of Changes section of the manual.

Please contact the ISO Customer Support Center at 1-800-888-4476 or send e-mail to claimsearchmsp@iso.com for more information. ✦

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Office of Financial Management/Financial Services Group

September 30, 2011

Medicare Secondary Payer Mandatory Reporting Provisions in
Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)
(See 42 U.S.C. 1395y(b)(7)&(b)(8))

ALERT

Revised Implementation Timeline for Certain Liability Insurance (Including Self-Insurance) Total Payment Obligation to the Claimant (TPOC) Settlements, Judgments, Awards or Other Payments

The Centers for Medicare & Medicaid Services (CMS) has delayed Section 111 reporting for certain liability insurance (including self-insurance) TPOC settlements, judgments, awards, or other payments. The implementation date for reporting will be based on the TPOC amount. Below is a schedule of the new dates.

TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over $100,000	October 1, 2011	January 1, 2012
TPOCs over $50,000	April 1, 2012	July 1, 2012
TPOCs over $25,000	July 1, 2012	October 1, 2012
All TPOCs over min. threshold	October 1, 2012	January 1, 2013

The CMS has not changed any other MMSEA Section 111 implementation dates. See the applicable MMSEA Section 111 User Guide. In addition, other relevant information, including explanations of TPOC, ORM, and a Responsible Reporting Entity, can be found in the User Guide. (Note: This delay is optional).

The content of this ALERT supersedes the content of the existing User Guide (Version 3.2) and will be incorporated into the next version of the User Guide. After full implementation of the Section 111 reporting requirements, CMS will use the normal notice of proposed rulemaking process for establishing any penalties.

(4/10/2012) Paula Pernal - MMSEA Section 111 Bulletin

From: "ClaimSearchMSP" <claimsearchmsp@iso.com>
To:
Date: 4/9/2012 11:00 AM
Subject: MMSEA Section 111 Bulletin

<http://blog.cpscmsa.com/>

MMSEA Section 111 Bulletin:

Liability TPOC Reporting Extension

Amount Resets as of April 1, 2012

The current phase of CMS' MMSEA Section 111 reporting for liability TPOCs (settlements, judgments, awards, or other payments) commenced on April 1, 2012.

Previously, liability TPOCs greater than $100,000 for TPOC dates from October 1, 2011 through March 31, 2012 were reportable under CMS' Section111 reporting directives.

Starting April 1, 2012, the liability TPOC reporting extension was reduced from $100,000 to $50,000. Thus, all liability TPOCs greater than $50,000 for TPOCs on or after April 1, 2012 through June 30, 2012 are now reportable.

Looking ahead, the liability TPOC reporting extension amounts are then scheduled to reset again on July 1, 2012 and October 1, 2012. Thereafter, the threshold amounts will change in 2013 and 2014.

The following provides an outline of CMS' current liability TPOC reporting dates and mandatory or optional thresholds:

Dates

Mandatory Threshold

Optional Threshold

10/1/11 -- 3/31/12

Claims > $100,000

Claims > $5,000

4/1/12 -- 6/30/12

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Centers for Medicare & Medicaid Services (CMS)

MMSEA Section 111 Mandatory Insurer Reporting

Quick Reference Guide

Version 1
January 19, 2012

For

Non-Group Health Plan (NGHP) Insurers

The What, Why and How of MMSEA Section 111 Reporting

The Centers for Medicare & Medicaid Services (CMS) refers to liability insurance (including self-insurance), no-fault insurance and workers' compensation as "Non-Group Health Plan" (NGHP) insurance. This MMSEA Section 111 Quick Reference Guide has been developed to help NGHP insurers understand the MMSEA Section 111 reporting requirements.

Specifically this guide will:

- Explain MMSEA Section 111 reporting, and how it may affect you
- Help you determine if you are an MMSEA Section 111 "Responsible Reporting Entity" (RRE)
- Provide an overview on how to set up and begin reporting
- Describe the various options you have for reporting
- Outline the data "input and response" process
- Identify resources for additional instruction and information on how to access free computer based training and other resources

Note: This document was prepared by the CMS for informational purposes only. All affected entities are responsible for following the instructions found in the MMSEA Section 111 NGHP User Guide which is available for download at the following link: http://www.cms.gov/MandatoryInsRep/Downloads/NGHPGuideV3.3.pdf.

What is MMSEA Section 111 Reporting?

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 is usually referred to as MMSEA Section 111 reporting (or simply Section 111). This law added *mandatory* reporting requirements for liability insurers (including self-insurers), no-fault insurers, and workers' compensation insurers providing coverage to Medicare beneficiaries. These Non-Group Health Plan (NGHP) insurers are obligated to notify Medicare about "settlements, judgments, awards, or other payment from liability insurers (including self-insurers), no-fault insurers, and workers' compensation" received by or on behalf of Medicare beneficiaries. The reporting requirements for NGHP insurers under MMSEA Section 111 first became effective on May 1, 2009.

The MMSEA Section 111 reporting requirements is *an addition* to the already existing Medicare Secondary Payer (MSP) law and corresponding regulations.

What is Medicare Secondary Payer – MSP?

Medicare Secondary Payer (MSP) is the term used to describe situations where another insurer has primary payment responsibility for care provided to a Medicare beneficiary.

Until 1980, Medicare was a primary payer for covered beneficiaries in almost all cases, except those involving workers' compensation (and black lung disease). Starting in 1980, the addition of the MSP provisions of the Social Security Act required that when the injured party is a Medicare beneficiary, Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance and workers' compensation.

Why is there an MSP law?

The MSP provisions of the Social Security Act were enacted so that some of the costs of caring for Medicare beneficiaries could be borne by other types of insurance. Spreading payment for health care coverage costs across multiple insurers is helping to extend the life of the Medicare Trust Fund, and is helping to ensure that Medicare beneficiaries have adequate access to care.

For more information and guidance about Medicare Secondary Payer (MSP) issues, please refer to "Section 5.4 - MSP Statutes, Regulations, and Guidance" in the NGHP User Guide.

I may be an "NGHP" insurer. Do I need to report under MMSEA Section 111?

You most likely will need to report under MMSEA Section 111 if you are "an applicable plan" – meaning that you are a liability insurer (including a self-insurer), an insurer providing "no-fault" coverage, or a workers' compensation plan. These are the main general categories of NGHP insurance types. In all cases, you provide insurance coverage or payments for medical expenses for someone who is a Medicare beneficiary. Please see Appendix H in the NGHP User Guide for a comprehensive discussion of the types of insurers that must report.

If you have determined that you need to report under MMSEA Section 111, you are the entity responsible for complying and will be will be referred to as the "Responsible Reporting Entity" or the "RRE".

Who do I report to?

Insurers are to report coverage to the Centers for Medicare & Medicaid Services – CMS – the Federal agency that manages the Medicare program. Since the start of MMSEA Section 111 reporting, almost 30,000 RREs are now sending MMSEA Section 111 data to CMS.

In order to manage the huge volume of MMSEA Section 111 data and other Coordination of Benefits (COB) work that Medicare handles, CMS has engaged the Coordination of Benefits Contractor (COBC) to manage the technical aspects of the Section 111 data exchange process for all Section 111 RREs. The RREs (or their data management agents) transmit information electronically to the CMS COBC.

I have determined that I need to comply with the MMSEA Section 111 reporting requirements. How do I sign up for it?

Insurers that need to report under MMSEA Section 111 become Responsible Reporting Entities (RREs) by registering on the Section 111 COB Secure Website (COBSW), a website established by CMS and managed by the COBC. RREs are required to register on the COBSW to notify the COBC of their intent to report data in compliance with Section 111.

To begin the registration process, go to the Section 111 COBSW at the following URL: http://www.section111.cms.hhs.gov and click the [I Accept] link at the bottom of the page. When the Section 111 COBSW Login page displays, click [New Registration]. You will be required to enter specific data and submit your registration. Once you have registered and completed your account setup for MMSEA Section 111 reporting on the Section 111 COBSW, you become a registered RRE. For more information on the registration process, please see the "How to Get Started" document found at the following link: https://www.section111.cms.hhs.gov/MRA/help/how_to/GetStarted.htm.

What information do I report? What will I be sending to the COBC?

Section 111 requires RREs to report claim information for Medicare beneficiaries after the insurer has assumed ongoing responsibility for medicals (ORM) or after paying the total payment obligation to the claimant (TPOC) in the form of a settlement, judgment, award, or other payment.

RREs must report evidence of insurance coverage, or applicable settlements, judgments, awards, or other payments regardless of whether there is admission or determination of liability. Some of the required data that must be reported includes: the identity of the claimant (their Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN), the first letter of their first name, the first six letters of their last name, their date of birth, and gender); the RRE Tax-ID Number (TIN); RRE address information; and other information related to the claimant such as International Classification of Diseases 9th revision (ICD-9) Diagnosis Codes; and, TPOC Dates and Amounts.

For more information on the specific data required, please see Appendix A and Appendix B in the NGHP User Guide.

How do I know or determine if I'm insuring a Medicare beneficiary?

Most Medicare beneficiaries are at least age 65. However, an individual of almost any age may be enrolled in the Medicare program. Medicare is a health insurance program for:

- People age 65 or older
- People of any age who have certain designated disabilities
- People of any age who have End-Stage Renal Disease (ESRD - permanent kidney failure)

When an individual is eligible for coverage and enrolls in Medicare, he or she is issued a "Medicare HICN", which is better known as the Medicare ID. The Medicare HICN/ID is derived from the individual's SSN. All Medicare beneficiaries will have a Medicare HICN and an SSN.

You will know if an individual is a Medicare beneficiary if you have been given the person's Medicare HICN. The easiest way to check for eligibility is to simply ask individuals you are insuring to give you their Medicare HICN. If you are unable to readily determine Medicare beneficiary status, the CMS provides a query process (search mechanism) as part of the Section 111 reporting process to assist you. In order to use the query process, you must be a registered RRE. Once registered, RREs must implement a procedure in their claims review process to determine whether the claimant is a Medicare beneficiary or if the claimant anticipates receiving Medicare benefits in the future.

How do I send the required information to the COBC?

MMSEA Section 111 reporting information can be exchanged with the COBC using any one of four methods. The first three methods involve the submission of electronic files.

- **HTTPS** – Hypertext Transfer Protocol over Secure Socket Layer: Using HTTPS, an RRE can transmit files via the Internet directly to the Section 111 COBSW and receive response files in the same manner. This method is recommended for RREs sending less than 24,000 records on a regular basis.
- **SFTP** – Secure File Transfer Protocol: Using SFTP software, an RRE can transmit files via the Internet directly to the COBC. The RRE will have a dedicated "mailbox" on the COBC's Section 111 SFTP Server, where the RRE will send input files and retrieve response files. This method can handle large amounts of data.
- **Connect:Direct** – This system provides a direct file transmission connection to the COBC mainframe using the CMS Extranet Network and CMS's private CMSNet. This is the most costly transmission method, but it is the most efficient for RREs that will be exchanging very large amounts of MMSEA Section 111 data with CMS.
- **Direct Data Entry (DDE)** – Using DDE, an RRE will manually enter claim information using an interactive application that will be accessed directly from the Section 111 COBSW. DDE can only be used by small reporters.

For more information on any of these data submission methods, please see "Section 15 – Electronic Data Exchange" in the NGHP User Guide.

Should I use Direct Data Entry?

Direct Data Entry, or DDE, is the simplest method of reporting MMSEA Section 111 data. DDE reporting is done through the Section 111 COBSW. DDE is designed for smaller RREs that don't expect to report much claim information under Section 111 (i.e., less than 500 claim reports per year). RREs using the DDE reporting option will manually key claim information into pages (screens) on the Section 111 COBSW. Once the claim is submitted and the COBC has completed its' processing, a response will be sent to the RRE via the Section 111 COBSW. For more information on the DDE process, please see the Section 111 COBSW User Guide which is available for download from the Section 111 COBSW under the 'Reference Materials' menu option. You must be logged into the Section 111 COBSW to gain access to the Section 111 COBSW User Guide.

Here are some important facts about DDE:

- An RRE can make, correct or update an MMSEA Section 111 claim report *at any time*.
- Although a separate query function is not available to DDE submitters, the initial step in the DDE process provides the same functionality.
- RREs using DDE can submit no more than 500 records a year.
  - All new DDE submissions for any purpose (even those where the Injured Party is not identified as a Medicare beneficiary) count against this annual limit.
  - Updates or deletes to a *previously submitted and* <u>*accepted*</u> claim report <u>do</u> count toward this limit.
  - Corrections to a *previously submitted, but* <u>*not yet accepted*</u> claim report due to errors, <u>do not</u> count against this limit.

How often do I submit my claim information?

RREs submitting electronic files must submit new or changed information on a quarterly basis during the RREs assigned 7-day file submission timeframe unless the RRE has nothing to report for a particular quarter. RREs using DDE to report must submit claim information one claim report at a time as soon as the conditions related to the claim require reporting under Section 111.

How do I know if what I sent was OK?

When the COBC receives a Claim Input File (or a DDE claim report), it will edit the data and determine whether the submitted information identifies the injured party as a Medicare beneficiary. When this processing is complete or the prescribed time for response file generation has elapsed, the COBC will electronically transmit a response file (for file submitters), or a response record (for DDE submitters).

Note: Each submitted record will receive a response. The response will include a disposition code that will give the RRE the results of the processing. The response will also include any error codes or compliance flags, which will identify any problems found with the data. The RRE must take the appropriate action, if any, based on the information received. If errors were received, they must be corrected and resubmitted in the RRE's next quarterly claim submission (file submitters), or as soon as the error has been corrected (DDE submitters).

Do I have to do this reporting myself? Can I hire a commercial data management firm to do it for me?

Once an RRE has registered, the RRE can delegate reporting responsibility to another entity such as a "data reporting agent" (e.g., a third party administrator or vendor) to manage the RRE's MMSEA Section 111 data exchanges with the COBC. Many do. If an RRE uses an agent to manage its MMSEA Section 111 reporting, here are some important points to keep in mind:

- You, the RRE, not your agent, are the Responsible Reporting Entity. You cannot assign your responsibility to report to your agent. The RRE is ultimately responsible for the reporting and will be held liable for non-compliance.
- You, the RRE, not your agent, are responsible for the content of the data and its' validity.
- Your agent may not use any MMSEA Section 111 reporting data other than to report for Section 111. The data belongs to the RRE and to the CMS, not to the agent.
- Your agent may use any data exchange transmission method acceptable to CMS.
- CMS does not make any recommendations about any potential reporting agents.

What MMSEA Section 111 reporting resource materials are available?

MMSEA Section 111 Mandatory Insurer Reporting Web site: The most important online resource is the official MMSEA Section 111 Mandatory Insurer Reporting Web site located at the following URL: http://www.cms.gov/mandatoryinsrep. The updated NGHP Section 111 User Guide and Section 111 Alerts can be found on this Web site.

Free Computer Based Training (CBT) Courses: CMS has made available a curriculum of computer based training (CBT) courses to Section 111 RREs. These courses are offered free of charge and provide in-depth training on Section 111 registration, reporting requirements, using the Section 111 COBSW, data transmission, file formats, file processing, Direct Data Entry, and general MSP topics. To register for the NGHP CBT courses, send an e-mail to: Section111CBT@EHMedicare.com. Specify that you are requesting the NGHP curriculum and include your company name and the name, phone number (formatted: ###-###-####) and e-mail address for the individual(s) you would like to register. Once the COBC has processed your company's request, an e-mail notification will be sent to each individual that contains the URL for the NGHP curriculum and the URL for the MSP curriculum. If you do not receive an e-mail notification within 2 business days of your request, you may contact the COBC's Electronic Data Interchange (EDI) Department at: 646-458-6740.

Section 111 Town Hall Teleconferences: From time to time CMS holds national Section 111 Town Hall Teleconferences that you may participate in. During these calls CMS addresses many of the questions and comments it receives through the Section 111 mailbox. Information about upcoming Town Hall Teleconferences is posted on the official MMSEA Section 111 Mandatory Insurer Reporting Web site at: http://www.cms.gov/mandatoryinsrep.

EDI Representative: Once an RRE has registered they will be assigned their own EDI Representative to assist them in managing all aspects of the Section 111 reporting process, from answering the simplest questions to helping them address the most complex problems.

Can I contact CMS directly with questions or comments?

If you have questions or concerns you want to communicate to CMS directly, you can use the dedicated Section 111 Mailbox at: PL110-173SEC111-comments@cms.hhs.gov.

We hope this Section 111 Mandatory Insurer Reporting Quick Reference Guide has been useful. If you have comments, questions on subjects not covered here, or suggestions about how this Quick Reference Guide can be improved, please feel free to send them to the dedicated Section 111 Mailbox at: PL110-173SEC111-comments@cms.hhs.gov. Please put "Quick Reference Guide" in the Subject line.

From: "techsupport" <techi@nhassociates.net>
To: "techsupport" <techi@nhassociates.net>
Date: 1/29/2012 5:37 PM
Subject: MMSEA Section 111 Quick Reference Guide

If you are having trouble viewing this email please click here.
<http://www.nhassociates.net/CMS_rollouts/NGHP_012612.html>

<https://www.cms.gov/COBGeneralInformation> COB Logo <https://www.cms.gov/> CMS Logo

MMSEA Section 111 Quick Reference Guide

The Centers for Medicare & Medicaid Services (CMS) has developed an MMSEA Section 111 Quick Reference Guide to help Non-Group Health Plan (NGHP) insurers understand the MMSEA Section 111 reporting requirements. This guide:

- Explains MMSEA Section 111 reporting, and how it may affect you
- Helps you determine if you are an MMSEA Section 111 "Responsible Reporting Entity" (RRE)
- Provides an overview on how to set up and begin reporting
- Describes the various options you have for reporting
- Outlines the data "input and response" process
- Identifies resources for additional instruction and information on how to access free computer based training and other resources

This guide has been posted to the Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation (NGHP) section page. To access this document go to this URL: https://www.cms.gov/MandatoryInsRep/Downloads/NGHPQuickRef.pdf

Thank you,

The Centers for Medicare & Medicaid Services
NHA Learning Management Team

<http://www.nhassociates.net/> NHA LogoTo unsubscribe, click here <mailto:techi@nhassociates.net?subject=UNSUBSCRIBE> or click "REPLY" and type "UNSUBSCRIBE" as the subject line of this message.

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CMS

Section 111
Mandatory Reporting

User Agreement

THE FOLLOWING DESCRIBES THE TERMS AND CONDITIONS BY WHICH THE CENTERS FOR MEDICARE MEDICAID SERVICES (CMS) OFFERS YOU ACCESS TO THE COORDINATION OF BENEFITS (COB) SECURE WEB SITE

You must read and accept the terms and conditions contained in this User Agreement expressly set out below and incorporated by reference before you may access the COB Secure Web site.

The CMS may amend this User Agreement at any time. Except as stated below, all amended terms shall automatically be effective 30 days after they are initially posted on the Site. This User Agreement is effective immediately.

1. Purpose of Section 111 Secure Web site

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), adds new Medicare Secondary Payer (MSP) mandatory reporting requirements for group health plan (GHP) arrangements and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation. The new provisions for GHP arrangements can be found at 42 U.S.C. 1395y(b)(7) and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation at 42 U.S.C. 1395y(b)(8). The purpose of the Section 111 MSP reporting process is to enable CMS to correctly pay for Medicare covered items and services furnished to Medicare beneficiaries by determining primary versus secondary payer responsibility. Section 111 responsible reporting entities may use the Section 111 COB Secure Web site to submit files for Section 111 MSP reporting. Additionally, this application will also provide a means for responsible reporting entities to review the status of current file submissions and statistical information related to historical submissions.

2. Privacy Policy

The U.S. Department of Health and Human Services (HHS) at (http://www.hhs.gov/), of which the CMS COB Secure Web site is a part, has a clear privacy policy. When you access the COB Secure Web site, we collect the minimum amount of information about you necessary to manage your account.

Information Automatically Collected and Stored

When you browse through any Web site, certain personal information about you can be collected. We automatically collect and temporarily store the following information about your visit:

- the name of the domain you use to access the Internet (for example, aol.com, if you are using an American Online account, or stanford.edu, if you are connecting from Stanford University's domain);
- the date and time of your visit;
- the pages you visited; and
- the address of the Web site you came from when you came to visit.

This information is used for statistical purposes only and to help us make this site more useful to visitors. Unless it is specifically stated otherwise, no additional information will be collected about you.

Information Collected through the COB Secure Web site

The personal information you provide is encrypted and sent to us using a secure method, in order to assure that your personal information is securely and safely transmitted. However, no one can give an absolute assurance that information intended to be maintained as private, whether transmitted via the Internet or otherwise, cannot be accessed inappropriately or unlawfully by third parties. We have taken and will continue to take reasonable steps to ensure the secure and safe transmission of your personal information.

Personally Provided Information

If you are not responsible for the MMSEA Section 111 MSP mandatory reporting using the COB Secure Web site, you do not have to give us personal information. If you choose to provide us with additional information about yourself through e-mail, forms, surveys, etc., we will maintain the information as long as needed to respond to your question or to fulfill the stated purpose of the communication.

Disclosure

HHS and CMS do not disclose, give, sell or transfer any personal information about its visitors, unless required for law enforcement or statute.

Intrusion Detection

The U.S. Government maintains the Web site. It is protected by various provisions of Section 1862(b) of the Social Security Act (42 USC 1395y(b)(5)), Publication 1075 of the Department of Treasury, Internal Revenue Service, and Title 18, U.S. Code. Violations of Title 18 are subject to criminal prosecution in federal court.

For site security purposes and to ensure that this service remains available to all Users, we employ software programs to monitor traffic to identify unauthorized attempts to upload or change information, or otherwise cause damage. In the event of authorized law enforcement investigations, and pursuant to any required legal process, information from these sources may be used to help identify an individual.

3. Systems of Records

Information originally collected in traditional paper systems can be submitted electronically, i.e., electronic commerce transactions and information updates about eligibility benefits. Electronically submitted information is maintained and destroyed pursuant to the Federal Records Act and in some cases may be subject to the Privacy Act. If information that you submit is to be used in a Privacy Act system of records, there will be a Privacy Act Notice provided.

4. Links

References from this Web site to any non-governmental entity, product, service or information do not imply endorsement or recommendation by the CMS, the HHS or any other HHS agency or employees

We are not responsible for the contents of any "off-site" Web pages referenced from this server. We do not endorse ANY specific products or services provided by public or private organizations. In addition, we do not necessarily endorse the views expressed by such sites, nor do we warrant the validity of any site's information or its fitness for any particular purpose.

5. Pop-up Advertisements

When visiting our web site, your web browser may produce pop-up advertisements. These advertisements were most likely produced by other web sites you visited or by third party software installed on your computer. The CMS does not endorse or recommend products or services for which you may view a pop-up advertisement on your computer screen while visiting our site.

6. Out-dated Information

Many HHS/CMS documents are time sensitive. Department policies change over time. Information in older documents may be out-dated. You also may wish to review our Privacy Policy, above.

7. Accessibility

This page provides information for those visitors who use assistive or other devices to access the content on this Web site. Please see our Contact section at http://cms.hhs.gov/contact/default.htm if you have general questions and comments or have difficulty finding something on this site.

Synopsis of Section 508 Accessibility Requirements

Section 508 requires that individuals with disabilities, who are members of the public seeking information or services from this Web site have access to and use of information and data that is comparable to that provided to the public who are not individuals with disabilities, unless an undue burden would be imposed on us. Section 508 also requires us to ensure that Federal employees with disabilities have access to and use of information and data that is comparable to the access to and use of information and data by Federal employees who are not individuals with disabilities, unless an undue burden would be imposed on us. (To learn more about the regulations governing the accessibility of Federal electronic information, read the Synopsis of Section 508 Accessibility Requirements at http://www.section508.gov/index8. Freedom of Information Act (FOIA)

The CMS COB Secure Web site is a service of the U.S. Department of Health and Human Services at http://www.hhs.gov/. Any Freedom of Information Act (FOIA) requests concerning this Web site should be submitted in accordance with the Department's FOIA guidelines, which are online at http://www.hhs.gov/foia. Information on making FOIA requests is available at the Freedom of Information Group page. You also may wish to review our Privacy Policy above.

8. 42 USC 1395y(b)(7) & (8)

(7) REQUIRED SUBMISSION OF INFORMATION BY GROUP HEALTH PLANS

(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 1 year after the date of the enactment of this paragraph, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan

administrator or fiduciary, shall

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this title; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) ENFORCEMENT

(i) IN GENERAL- An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.
(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1817.

(C) SHARING OF INFORMATION- Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary--

(i) shall share information on entitlement under Part A and enrollment under Part B under this title with entities, plan administrators, and fiduciaries described in subparagraph (A);
(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and
(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS

(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) REQUIRED INFORMATION- The information described in this subparagraph is

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and
(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

(C) TIMING- Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) CLAIMANT- - For purposes of subparagraph (A), the term `claimant' includes

(i) an individual filing a claim directly against the applicable plan; and
(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) ENFORCEMENT

(i) IN GENERAL- An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.
(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) APPLICABLE PLAN - In this paragraph, the term `applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or

administrator for such law, plan, or arrangement:

(i)Liability insurance (including self-insurance).
(ii) No fault insurance.
(iii) Workers' compensation laws or plans.

(G) SHARING OF INFORMATION- The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(H) IMPLEMENTATION - Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.'

(b) Rule of Construction- Nothing in the amendments made by this section shall be construed to limit the authority of the Secretary of Health and Human Services to collect information to carry out Medicare secondary payer provisions under title XVIII of the Social Security Act, including under parts C and D of such title.
(c) Implementation- For purposes of implementing paragraphs (7) and (8) of section 1862(b) of the Social Security Act, as added by subsection (a), to ensure appropriate payments under title XVIII of such Act, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportions as the Secretary determines appropriate, of $35,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2008, 2009, and 2010.

Privacy Act Statement

The collection of this information is authorized by 42 U.S.C. 1395y(b)(7) & (8). The information collected will be used to identify and recover past mistaken Medicare primary payments and to prevent Medicare from making mistakes in the future for those Medicare Secondary Payer situations that continue to exist.

SAFEGUARDING & LIMITING ACCESS TO EXCHANGED DATA

I agree to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged for the purposes of complying with the Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. § 1306], Section

1874(b) of the Social Security Act [42 U.S.C. § 1395k(b)], Section 1862(b) of the Social Security Act [42 U.S.C. § 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. § 552a]. The Responsible Reporting Entity shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by CMS. I agree that the authorized representatives of CMS shall be granted access to premises where the Medicare data is being kept for the purpose of inspecting security arrangements confirming whether the Responsible Reporting Entity is in compliance with the security requirements specified above. Access to the records matched and to any records created by the matching process shall be restricted to authorized CMS and Responsible Reporting Entity employees, agents and officials who require access to perform their official duties in accordance with the uses of the information as authorized under Section 111 of the MMSEA of 2007. Such personnel shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.