Medicare Enrollment Center File Layout

Version 1.9

The file format listed below will be used to send all application information to the applicable organization. It is expected that the organizations will then submit the application following their normal process to CMS. This document contains all fields that will be provided for PDP and MAPD enrollments via the Online Enrollment Center.

File Layout:

The file will be a standard text file that is tab delimited with the first row contains the column names.

File Format:

#	Field	Format	Required		Example	Comment
			PDP	MA-PD		
1	ConfirmationNumber	Alpha/Numeric	Yes	Yes	XYY1234	The confirmation associated to the application.
2	SubmitDate	Numeric	Yes	Yes	MMDDYYYY	The submission date of the application.
3	ContractID	Alpha/Numeric	Yes	Yes	H0001	The Contract ID of the plan the applicant is applying
4	PlanID	Numeric	Yes	Yes	001	The Plan ID of the plan the applicant is applying.
5	SegmentID	Numeric	Yes	Yes	000	The Segment ID of the plan the applicant is applying (when this does not apply 000 will still be passed).
6	ApplicantTitle	Alpha	Yes	Yes	Mr.	The title of the applicant.
7	ApplicantFirstName	Alpha/Numeric	Yes	Yes	John	The first name of the applicant.

			Required			
8	ApplicantMiddleInitial	Alpha	No	No	H.	The middle initial of the applicant.
9	ApplicantLastName	Alpha/Numeric	Yes	Yes	Smith	The last name of the applicant.
10	ApplicantBirthDate	Numeric	Yes	Yes	MMDDYYYY	The birth date of the applicant.
11	ApplicantGender	Alpha	Yes	Yes	F	The gender of the applicant.
12	ApplicantAddress1	Alpha/Numeric	Yes	Yes	1234 Orange	Address of applicant
13	ApplicantAddress2	Alpha/Numeric	No	No	Apt 24	Address of applicant
14	ApplicantAddress3	Alpha/Numeric	No	No	#21	Address of applicant
15	ApplicantCity	Alpha/Numeric	Yes	Yes	Any city	City of applicant
16	ApplicantState	Alpha	Yes	Yes	CA	State of applicant
17	ApplicantZip	Numeric	Yes	Yes	90010	Zip of applicant
18	ApplicantPhone	Numeric	Yes	Yes	1234567890	Phone number of applicant
19	ApplicantEmailAddress	Alpha/Numeric	No	No	applicant@123xyz.com	Email address of applicant
20	ApplicantHICN	Alpha/Numeric	Yes	Yes	123456789A	HICN of applicant
21	ApplicationSSN	Alpha/Numeric	No	No	555-555-5555	SSN of applicant
22	MailingAddress1	Alpha/Numeric	No	No	1234 Street	Mailing Address of applicant
23	MailingAddress2	Alpha/Numeric	No	No	Apt 24	Mailing Address of applicant
24	MailingAddress3	Alpha/Numeric	No	No	#21	Mailing Address of applicant
25	MailingCity	Alpha/Numeric	No	No	Any City	Mailing City of applicant
26	MailingState	Alpha	No	No	CA	Mailing State of applicant
27	MailingZip	Numeric	No	No	90010	Mailing Zip Code of applicant
28	MedicarePartA	Numeric	*	*	MMDDYYYY	Effective Date of Medicare Part A

			Required			
29	MedicarePartB	Numeric	*	*	MMDDYYYY	Effective Date of Medicare Part B
30	EmergencyContact	Alpha/Numeric	No	No	Jane Smith	Name of emergency contact
31	EmergencyPhone	Numeric	No	No	1234567890	Phone of emergency contact
32	EmergencyRelationship	Alpha/Numeric	No	No	Friend	Relationship of emergency contact
33	PremiumDeducted	Alpha	Yes	Yes	Yes	Answer if the applicant wants their premium deducted. Note, this value should always be the opposite of *PremiumDirectPay* below, i.e. YES to PremiumDeducted = NO to PremiumDirectPay.
34	PremiumSource	Alpha	**	**	Social Security	Source of where premium should be deducted
35	OtherCoverage	Alpha	No	No	No	Answer if applicant has other coverage.
36	OtherCoverageName	Alpha/Numeric	***	***	My Coverage	Name of applicants other coverage
37	OtherCoverageID	Alpha/Numeric	***	***	1234567890	ID # of applicants other coverage
38	LongTerm	Alpha	Yes	Yes	Yes	Answer to if applicant is a resident of a Longer Term Facility
39	LongTermName	Alpha/Numeric	****	****	Institution Name	Name of Long Term Institution
40	LongTermAddress	Alpha/Numeric	****	****	1234 Street	Street of Long Term Institution
41	LongTermPhone	Numeric	****	****	1234567890	Phone of Long Term Institution
42	AuthorizedRepName	Alpha/Numeric	No	No	Joe Smith	Name of Authorized Representative
43	AuthorizedRepAddress	Alpha/Numeric	No	No	1234 Street	Address of Authorized Representative
44	AuthorizedRepCity	Alpha/Numeric	No	No	Any City	City of Authorized Representative

			Required			
45	AuthorizedRepState	Alpha	No	No	CA	State of Authorized Representative
46	AuthorizedRepZip	Numeric	No	No	90010	Zip of Authorized Representative
47	AuthorizedRepPhone	Numeric	No	No	1234567890	Phone of Authorized Representative
48	AuthorizedRepRelationship		No	No	Caregiver	Relationship of Authorized Representative
49	Language	Alpha	No	No	Spanish	Language other than English that is preferred
50	ESRD	Alpha	No	Yes	Yes	Answer to End State Renal Disease (ESRD) **For MAPD Enrollment**
51	StateMedicaid	Alpha	No	Yes	Yes	Answer to Enrolled in State Medicaid **For MAPD Enrollment**
52	WorkStatus	Alpha	No	Yes	Yes	Answer to if enrollee or spouse works **For MAPD Enrollment**
53	PrimaryCarePhysician	Alpha/Numeric	No	No	Dr. Jones	Name of Primary Care Physician **For MAPD Enrollment**
54	OtherCoverageGroup	Alpha/Numeric	No	No	Plan001	Group information about the OtherCoverage, if applicable.
55	AgentID	AlphaNumeric	No	No	MC8889995555	For enrollments from a sponsor's enrollment portal only, the agentID entered.
56	SubmitTime	Alpha	Yes	Yes	2005-11-14 00:27:44.023	Indicates full time stamp of enrollment in Pacific Standard Time
57	PartDSubAppInd	Alpha	No	No	"Y" or "N"	Indicates the LIS approval status of the user.
58	DeemedInd	Alpha	No	No	"Y" or "N"	Indicates whether the user is

			Required			
						deemed as eligible for subsidy by CMS or not. If DeemedInd = Y then user is considered to be at Full subsidy with subsidy level of 100.
59	SubsidyPercentage	Alpha	No	No	000, 025, 050, 075, 100	The subsidy level of the user. Only matters if the DeemedInd = N and PartDSubAppInd = Y.
60	DeemedReasonCode	Alpha/Numeric	No	No	“2A”, “12”	Indicates whether the user is full dual or full subsidy. Only look at this when DeemedInd = Y
61	LISCopayLevelID	Numeric	No	No	“1”, “4”	Indicates whether the user is full subsidy or partial subsidy. Only look at this when DeemedInd = N and PartDSubAppInd = Y
62	DeemedCopayLevelID	Numeric	No	No	“1”, “2”, “3”	Indicates the different co-pays that the user is required to pay based on his/her situation. Look at this element when DeemedInd = Y
63	PartDOptOutSwitch	Alpha	No	No	“Y” or “N”	Indicates whether the user opted out or in for the part D enrollment. If the value of this parameter is “Y”, then the beneficiary will not be auto-enrolled by the system.
64	SEPReasonCode	Alpha	No	No	XXX, YYY	Comma separated list of codes from SEP Reason Code Lookup below indicating why the beneficiary is

			Required			
						enrolling outside of the standard enrollment period.
65	SEPCMSReason	Alpha	No	No	Special Exceptions Enrollment Approved by CMS	Only used by CMS staff indicating why the beneficiary has been approved for Special Exceptions Enrollment. Entries in this field will be standardized with regards to content and characters. The list of acceptable data elements will be published separately.
66	PremiumDirectPay	Alpha	Yes	Yes	No	Answer if the applicant wants to pay their premium directly to the plan. Note, this value should always be the opposite of *PremiumDeducted* above, i.e. YES to PremiumDeducted = NO to PremiumDirectPay.

* Either Medicare Part A or Part B (or both) must be filled in.
** IF Premium Deducted is Yes, then this value is required.
*** IF Other Coverage is Yes, then this value is required.
**** IF Long Term is Yes, then this value is required.

SEP Reason Code Lookup		
SEP Reason Text	**SEP Reason Code**	**Active**
I am new to Medicare.	**NEW**	**true**
I recently moved outside of the service area for my current plan.	**MOV**	**true**

I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.	**MDE**	**true**
I was recently approved for extra help paying for Medicare prescription drug coverage.	**LIS**	**true**
I live in a Long Term Care Facility (for example, a nursing home	**LTC**	**true**
I recently "left" a PACE program.	**PAC**	**true**
I moved "out" of a Long Term Care Facility (for example, a nursing home or rehabilitation hospital).	**LLT**	**true**
I recently involuntarily lost my creditable drug coverage.	**LCC**	**true**
I am losing coverage I had from an employer	**LEC**	**true**
I live in a Hurricane Katrina Zip Code.	**KAT**	**true**
I belong to a pharmacy assistance program provided by my state.	**PAP**	**true**
I am in a Medicare Advantage plan with prescription drug coverage and am still in my 12 month trial period.	**MAT**	**FALSE**
I recently returned to the United States after living permanently outside of the U.S.	**RUS**	**True**
In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan* for the first time (*Medicare Advantage plan with prescription drug coverage)	**12G**	**True**
In the last 12 months, I joined a Medicare Advantage plan with prescription drug coverage when I turned 65.	**12J**	**True**
Other	**OTH**	**True**