Grouping	Data Name	Process Name	REQ	Format Length	Format Type	Begin	End
Transaction	TRANSACTION SET ID	TRNS_SET_ID	M	3	A/N	1	3
	MAINTENANCE TYPE CODE	MTC	M	2	A/N	4	5
	MAINTENANCE TYPE CODE DATE	MTC_DT	O	8	DATE	6	13
Juridiction	JURISDICTION	JURIS	O	2	A/N	14	15
	AGENCY CLAIM NUMBER	AGCY_CLM_NBR	O	25	A/N	16	40
Clm Admin	INSURER FEIN	INSURER_FEIN	M	9	A/N	41	49
	INSURER NAME	INSURER_NAME	M	30	A/N	50	79
	THIRD PARTY ADMINISTRATOR FEIN	INSURER_FEIN	M**	9	A/N	80	88
	THIRD PARTY ADMINISTRATOR NAME	INSURER_NAME	O	30	A/N	89	118
	CLAIM ADMINISTRATOR ADDRESS LINE 1	CLM_ADM_ADDR_1	M	30	A/N	119	148
	CLAIM ADMINISTRATOR ADDRESS LINE 2	CLM_ADM_ADDR_2	O	30	A/N	149	178
	CLAIM ADMINISTRATOR CITY	CLM_ADM_CTY	M	15	A/N	179	193
	CLAIM ADMINISTRATOR STATE	CLM_ADM_STATE	M	2	A/N	194	195
	CLAIM ADMINISTRATOR POSTAL CODE	CLM_ADM_POSTAL	M	9	A/N	196	204
	CLAIM ADMINISTRATOR CLAIM NUMBER	CLM_ADM_CLM_NBR	O	25	A/N	205	229
Insured	EMPLOYER FEIN	EMPLR_FEIN	M	9	A/N	230	238
	INSURED NAME	INSD_NAME	O	30	A/N	239	268
	EMPLOYER NAME	EMPLR_NAME	M	30	A/N	269	298
	EMPLOYER ADDRESS LINE 1	EMPLR_ADDR_1	M	30	A/N	299	328
	EMPLOYER ADDRESS LINE 2	EMPLR_ADDR_2	O	30	A/N	329	358
	EMPLOYER CITY	EMPLR_CITY	M	15	A/N	359	373
	EMPLOYER STATE	EMPLR_STATE	M	2	A/N	374	375
	EMPLOYER POSTAL CODE	EMPLR_POSTAL	M	9	A/N	376	384
	SELF INSURED INDICATOR	SELF_INSD_IND	O	1	A/N	385	385
	SIC CODE	SIC_CODE	O	6	A/N	386	391
	INSURED REPORT NUMBER	INSD_RPT_NBR	O	10	A/N	392	401
	INSURED LOCATION NUMBER	INSD_LOC_NBR	O	15	A/N	402	416
Policy	POLICY NUMBER	POL_NUM	O	30	A/N	417	446
	POLICY EFFECTIVE	POL_EFF	O	8	DATE	447	454
	POLICY EXPIRATION	POL_EXP	O	8	DATE	455	462
Accident	DATE OF INJURY	DT_INJ	M	8	DATE	463	470
	TIME OF INJURY	TIME_INJ	O	4	HHMM	471	474
	POSTAL CODE OF INJURY	POSTAL_INJ_SITE	O	9	A/N	475	483
	EMPLOYER PREMISES INDICATOR	EMPLR_PREMIS_IND	O	1	A/N	484	484
	NATURE OF INJURY	NATURE_INJ_CD	M	2	A/N	485	486
	PART OF BODY INJURED CODE	PART_BODY_INJ_CD	M	2	A/N	487	488
	CAUSE OF INJURY	CAUSE_INJ_CD	M	2	A/N	489	490
	ACCIDENT DESCRIPTION/CAUSE	ACC_DESC_TXT	O	150	A/N	491	640

	INITIAL TREATMENT	INIT_TREAT_CD	O	2	A/N	641	642
	DATE REPORTED TO EMPLOYER	DT_REP_EMPLR	O	8	DATE	643	650
	DATE REPORTED TO CLAIMS ADMINISTRATOR	DT_REP_CLM_ADM	O	8	DATE	651	658
Employee	SOCIAL SECURITY NUMBER	SSN	M	9	A/N	659	667
	EMPLOYEE LAST NAME	EE_L_NAME	M	30	A/N	668	697
	EMPLOYEE FIRST NAME	EE_F_NAME	M	15	A/N	698	712
	EMPLOYEE MIDDLE INITIAL	EE_MI	O	1	A/N	713	713
	EMPLOYEE ADDRESS LINE 1	EE_ADDR1	M	30	A/N	714	743
	EMPLOYEE ADDRESS LINE 2	EE_ADDR2	O	30	A/N	744	773
	EMPLOYEE CITY	EE_CITY	M	15	A/N	774	788
	EMPLOYEE STATE	EE_STATE	M	2	A/N	789	790
	EMPLOYEE POSTAL CODE	EE_POSTAL	M	9	A/N	791	799
	EMPLOYEE PHONE NUMBER	EE_PHONE	O	10	A/N	800	809
	EMPLOYEE DATE OF BIRTH	EE_DT_BIRTH	M	8	DATE	810	817
	GENDER CODE	GENDER_CD	O	1	A/N	818	818
	MARITAL STATUS CODE	MARITAL_CD	O	1	A/N	819	819
	NUMBER OF DEPENDENTS	NBR_DEPS	O	2	NUM	820	821
	DATE DISABILITY BEGAN	DATE_DIS_BGN	O	8	DATE	822	829
	EMPLOYEE DATE OF DEATH	EE_DT_DEATH	O	8	DATE	830	837
Employment	EMPLOYMENT STATUS CODE	EMPLYMNT_STATUS	O	2	A/N	838	839
	CLASS CODE	CLASS_CD	O	4	A/N	840	843
	OCCUPATION DESCRIPTION	OCCUP_DESCR	O	30	A/N	844	873
	DATE OF HIRE	DT_HIRE	O	8	DATE	874	881
	WAGE	WAGE	O	11	NUM	882	892
	WAGE PERIOD	WAGE_PERIOD	O	2	A/N	893	894
	NUMBER OF DAYS WORKED	NBR_DYS_WKD	O	1	NUM	895	895
	DATE LAST DAY WORKED	DT_LAST_DY_WKD	O	8	DATE	896	903
	FULL WAGES PAID FOR THE DATE OF INJURY INDICATOR	FULL_WAGES_L_DAY	O	1	A/N	904	904
	SALARY CONTINUED INDICATOR	SAL_CONT_IND	O	1	A/N	905	905
	DATE OF RETURN TO WORK	DT_RTW	O	8	DATE	906	913

** If there is no TPA, leave this field blank, or use the insurer's FEIN.