NYSIF Enrollment Record							Exhibit II.O
Item #	Field Name	Field Format	Field Length	Field Location From	Field Location To	Required (R) Optional (O)	Description of Field Values and Comments
1	Record Type	A/N	1	1	1	R	Type of eligibility record being send.
							Format: Value = 'W'
2	Master Carrier	A/N	4	2	5	R	Master carrier code assigned by PBM.
3	Subcarrier	A/N	4	6	9	R	Subcarrier code assigned by PBM. Identifies the client providing the claimant eligibility data.
4	Group Number	A/N	15	10	24	R	Group coverage code.
5	Claimant ID	A/N	18	25	42	R	Unique identifier, usually SSN.
6	Claimant Last Name	A/N	20	43	62	R	Last name. Modifiers such as JR, SR, etc. should follow the last name.
7	Claimant First Name	A/N	15	63	77	R	First Name
8	Claimant Middle Initial	A/N	1	78	78	O	Middle Initial.
9	Address1	A/N	40	79	118	R	Mailing Address Line 1
10	Address2	A/N	40	119	158	R	Mailing Address Line 2
11	City	A/N	20	159	178	R	City.
12	US State or Canadian Province code	A/N	2	179	180	R	For US residents, use USPS 2 character State abbreviation. 'XX' if unknown.
13	Postal Code	A/N	9	181	189	R	Zip Code. If Plus 4 digit extended ZIP is unknown, zero fill.
14	Date of Birth	A/N	8	190	197	R	Date of birth . Format = CCYYMMDD.
15	Gender Code	A/N	1	198	198	R	Gender Code. Format = M - Male; F = Female; U - Unknown.
16	Date of injury	A/N	8	199	206	R	Date of Accident. Format = CCYYMMDD
17	Termination Date	A/N	8	207	214	R	Coverage termination date. Format = CCYYMMDD. If no termination date, value = ZEROES.
18	Customer Claim Number	A/N	20	215	234	O	Unique identifier.
19	State of Jurisdiction	A/N	2	235	236	O	State in which the Workers' Compensation claim was filed.

							'NY' if New York, else blank.
20	Misc Value (subgroup)	A/N	10	237	246	O	Client specific. This field is may be used for the separation in billing reports for the group,etc. Values are established by the client. NYISF values = District Office.
21	Status Flag		1	247	247	R	Claim Status. Format: A – Approved; P - Pended; D - Disallowed;
22	Status Msg Code	A/N	2	248	249	O	Injury status,
23	Merge Claim ID	A/N	10	250	259	O	Indicates that the current record (based on claimant ID) must be merged with an existing claimant ID.
24	Client Claim Examiner	AN	10	260	269	R	Claim Manager Unique ID NYSIF - Unit number to which the claim is assigned.
25	Filler		40	270	309		Reserved for future use.
26	Short Fill Cap Amt Override	N	6	310	315	O	Indicates an override of the client's short fill cap amt (set at subcarrier). Format 999.99
27	Doctor Network	A/N	3	316	318	O	The doctor network of which the claimant is a member.
28	Short Fill Days Supply Override	N	2	319	320	O	Indicates an override of the client's short fill days supply (set at subcarrier)
29	Short Fill Number of refills override	N	1	321	321	O	Indicates an override of the client's short fill number of refills allowed (set at carrier)
30	Grace days		3	322	324	O	The number of days difference between date of injury and date of service.
31	Co-pay Amount	N	5	325	329	O	co-pay dollar amount or percentage of co-pay liability. Indicates the percentage of non NYSIF liability. The format needs to be supplied.
32	Co-pay Indicator	A/N	1	330	330	O	Indicates whether the co-pay Amount field is a dollar or percent amount. Format: D - Dollar Amount; P - Percentage. NYSIF default = P.
33	Policy number	A/N	15	331	345	O	Workers' Compensation Policy Number of the Claimant's Employer.
34	Catastrophic Indicator	A/N	1	346	346	O	
35	Filler		20	347	366	O	Reserved for future use.

36	DEA Number	A/N	50	367	416	O	Doctor DEA-number. Five occurrences of 10 characters each.
37	Drug Therapy Restriction	A/N	370	417	786	O	Therapy class . Maximum of 10 occurrences, each occurrence consists of 22 character and is defined as follows:
							Effective Date (N,8) - format CCYYMMDD
							Termination Date (N, 8) - format CCYYMMDD
							Beginning Therapy Code (A/N, 3)
							Ending Therapy Code (A/N, 3)
38	Filler	A/N	360	787	1146	O	Reserved for future use.
39	Filler	A/N	353	1147	1499	O	Reserved for future use.