Medical Claims Data Request

Sympl Benefits is requesting medical claims data for the purposes of evaluating our network and presenting a savings and opportunity analysis.

Data Requirements

- Please provide medical claims data for your most recent full plan year (e.g., claims with Service Dates between January 1, 2024, and December 31, 2024). **Two years of data is preferred (include prior plan year).**
- For confidentiality purposes, please ensure that any member information provided is de-identified blinded, or scrambled. **The file should not contain any PII/PHI.**
- Medical claims should be provided at the medical claim line-level, meaning that for most claims, we will see multiple claim lines per claim. Each row of data in the file should represent one claim line.
- Please be sure to include leading zeros for any data element where this may be applicable.
- Request/Send the data elements in the format specified in the table at the end of this document.

File Format and Data Transfer

- Send the medical claims file as a .xlsx or .csv file.
- Send the medical claims file via email. While the file should not contain any PII/PHI, for confidentiality purposes, we still recommend encrypting the file before sharing with us. Please include instructions for decryption. (PW, secure FTP, etc)
- If the file is too large to send via email, please contact help@symplbenefits.com. We are happy to create a secure file transfer protocol via MS Sharepoint.

Please reach out to help@symplbenefits.com if you have any questions or need any assistance with this data request.

sympl BENEFITS

Medical Claims Data Specifications

Column	Data Element	Data Type	Required	Description	Example
1	Blinded Member ID	Text	Required	Unique identifier for a member. This value should be consistent for every instance of the member in the data. **This field should be blinded or scrambled and must not contain any PII/PHI**	a23v4510
2	Member Relationship	Text	Required	Member's relationship to subscriber	Subscriber, Spouse, or Dependent
3	Member Gender	Text	Required	Member's gender (one character)	M, F, or U
4	Member Birth Year	Number	Required	Year the member was born	1987
5	Member Zip Code	Number	Required	5-digit zip code for member's home address. If we cannot get member zip, we would like to receive provider zip	48103
6	Member State	Text	Required	2-digit state code for member's home address	WI
7	Member Plan Identifier	Text	Required	Name of the plan on which the member is enrolled	HDHP w/ HSA, PPO Copay Plan, etc.
8	Medical Claim Type	Text	Required	Indicates the general service category for each claim	Inpatient, Outpatient, or Professional
9	Medical Claim ID	Text	Required	Unique identifier for a claim. Should be consistent for all instances of the claim in the data. **Please ensure this field does not contain any PII/PHI**	C410g26c
10	Medical Claim Line	Number	Optional	Line number for an individual service that is part of a claim. *Note: While this field is not required, we must receive all claim lines that are part of a medical claim, even if they don't have an assigned line number*	1, 2, 3, 4, etc.
11	Service From Date	Date	Required	Date service started as YYYY-MM-DD	2023-06-01
12	Service To Date	Date	Required	Date service ended as YYYY-MM-DD *Note: In many cases, this value will be the same as the Service From Date*	2023-06-05
13	Place of Service Code	Number	Required	2-digit CMS Place of Service Code. See here	11
14	Revenue Code	Number	Required	4-digit UB-04 Revenue Code. See here *Note: Not every claim line will have a revenue code*	0360
15	CPT / HCPCS Code	Text	Required	5-character CPT (see here) or HCPCS Code (see here) *Note: Not every claim line will have a CPT or HCPC Code*	99215
16	CPT / HCPCS Modifier	Text	Required	2-character modifier that further describes the CPT or HCPCS Code. See here	26
17	Units or Days	Number	Required	Number of units or days that were administered	2
18	Plan Paid Amount	Currency	Required	Amount paid by the plan for the claim	$75.00
19	Member Paid Amount	Currency	Required	Amount paid by the member for the claim	$25.00

20	Allowed Amount	Currency	Required	Maximum amount a plan will pay for a covered healthcare service. May be referred to as “eligible expense,” “payment allowance,” or “negotiated rate.” This can also be calculated by adding the Plan Paid Amount and Member Paid Amount	$100.00
21	Billed Amount	Currency	Required	Billed Charges for the service	$200.00
21	Paid Date	Date	Optional	Date the claim was paid by the plan as YYYY-MM-DD	2023-07-01
22	Primary Diagnosis Code	Text	Required	Primary ICD-10 Diagnosis Code on the medical claim. See here	E089
23	MS-DRG Code	Number	Required	3-digit MS-DRG Code. See here	792
24	Provider Name	Text	Required	Name of the **physician or facility** who rendered the service	Dr. John Doe
25	Provider NPI	Number	Required	10-digit National Provider Identifier (NPI) for the provider rendering the service	1234567890
26	Provider TIN	Number	Required	9-digit Tax Identification Number (TIN) for the provider rendering the service	987654321
27	Provider Taxonomy Code	Text	Optional	10-digit Taxonomy Code for the provider rendering the service. See here	207Q00000X
28	Provider Zip Code	Number	Optional	5-digit practice location zip code (physical location where the service was rendered)	53207