

Field Name	Field Description	Header Row Column Name	Output Field Length ***	Field Length including delimiter/EOR Marker	Starting Position (relative 1)	BIAR Source Data Type ***	BIAR Source Table	BIAR Source Field Name	BIAR Transformation Logic
Recipient ID	Recipient's Medicaid ID number.	R-MedicaidID	CHAR(12)	13	1	CHAR(12)	DSS.T_RE_BASE_DN	ID_MEDICAID	
Recipient First Name	Recipient First Name	R-First Name	CHAR(15)	16	14	CHAR(15)	DSS.T_RE_BASE_DN	NAM_FIRST	
Recipient Middle Initial	Recipient Middle Initial	R-MI	CHAR(4)	5	30	CHAR(1)	DSS.T_RE_BASE_DN	NAM_MID_INIT	fill with trailing spaces
Recipient Last Name	Recipient Last Name	R-Last Nm	CHAR(20)	21	35	CHAR(20)	DSS.T_RE_BASE_DN	NAM_LAST	
Recipient Street 1	Recipient residence address, Street 1	R-Street1	CHAR(60)	61	56	CHAR(60)	DSS.T_RE_BASE_DN	ADR_STREET_1	
Recipient Street 2	Recipient residence address, Street 2	R-Street2	CHAR(60)	61	117	CHAR(60)	DSS.T_RE_BASE_DN	ADR_STREET_2	
Recipient City	Recipient residence address, City	R-City	CHAR(30)	31	178	CHAR(30)	DSS.T_RE_BASE_DN	ADR_CITY	
Recipient State	Recipient residence address, State	R-ST	CHAR(4)	5	209	CHAR(2)	DSS.T_RE_BASE_DN	ADR_STATE	fill with trailing spaces
Recipient Residence Zip Code	Recipient residence address, Zip Code	R-Zip	CHAR(5)	6	214	CHAR(5)	DSS.T_RE_BASE_DN	ADR_ZIP_CODE	
Recipient Residence Zip Code+4	Recipient residence address, Zip Code+4	R-Zip4	CHAR(6)	7	220	CHAR(4)	DSS.T_RE_BASE_DN	ADR_ZIP_CODE_4	fill with trailing spaces
Recipient Phone Number	Recipient's phone number.	R-Phone	CHAR(10)	11	227	CHAR(10)	DSS.T_RE_BASE_DN	NUM_PHONE	
Recipient Residence County	The recipient's residence county at the time when the claim was finalized.	R-Res Cty	CHAR(10)	11	238	CHAR(10)	DSS.T_RE_BASE_DN	CDE_COUNTY	
Recipient Gender	Recipient Gender	R-Gndr	CHAR(6)	7	249	CHAR(1)	DSS.T_RE_BASE_DN	CDE_SEX	fill with trailing spaces
Recipient Date of Birth	Recipient Date of Birth	R-DOB	DATE	9	256	DATE	DSS.T_RE_BASE_DN	DTE_BIRTH	format CCYYMMDD
Recipient Primary Language Code	Recipient Primary Language Code	R-Lang	CHAR(6)	7	265	CHAR(3)	DSS.T_RE_BASE_DN	CDE_LANGUAGE	fill with trailing spaces
Recipient Primary Language Code Description	Recipient Primary Language Code Description	R-Lang Desc	CHAR(100)	101	272	CHAR(100)	DSS.T_LANGUAGE	DSC_LANGUAGE	using appropriate CDE_LANGUAGE value.
Managed Care Plan Effective Date	If the recipient is actively enrolled in Managed Care within the report period, this value will be populated.	MC Eff Dte	DATE	9	373	DATE	DSS.T_RE_PMP_ASSIGN	DTE_EFFECTIVE	format CCYYMMDD  only populate this field if the following criteria is met:  if SAK_RECIP is found on T_RE_PMP_ASSIGN, check for spans with CDE_STATUS equal to a space (active). If found, check if the Effective Date on active span is less than or equal to the last day of the reporting period and the End Date is greater than or equal to the first day of the reporting period.
Managed Care Plan End Date	If the recipient is actively enrolled in Managed Care within the report period, this value will be populated.	MC End Dte	DATE	9	382	DATE	DSS.T_RE_PMP_ASSIGN	DTE_END	format CCYYMMDD  only populate this field if the following criteria is met:  if SAK_RECIP is found on T_RE_PMP_ASSIGN, check for spans with CDE_STATUS equal to a space (active). If found, check if the Effective Date on active span is less than or equal to the last day of the reporting period and the End Date is greater than or equal to the first day of the reporting period.
Managed Care Plan ID	The Medicaid ID for the managed care plan.	MC Plan ID	CHAR(15)	16	391	CHAR(15)	DSS.T_PR_SVC_LOC_DN	ID_PROVIDER_MCAID	only populate this field if the Managed Care Plan Effective/End dates are populated on the file. Use the following criteria:  WHERE ( ( DSS.T_RE_PMP_ASSIGN.SAK_PUB_HLTH=DSS.T_PMP_SVC_LOC.SAK_PUB_HLTH and DSS.T_RE_PMP_ASSIGN.SAK_PMP_SER_LOC=DSS.T_PMP_SVC_LOC.SAK_PMP_SER_LOC ) AND ( DSS.T_PMP_SVC_LOC.SAK_PROV=DSS.T_PR_SVC_LOC_DN.SAK_PROV and DSS.T_PMP_SVC_LOC.SAK_PROV_LOC=DSS.T_PR_SVC_LOC_DN.SAK_PROV_LOC ) ) )
Managed Care Plan Name	The name of the managed care plan.	MC Plan NM	CHAR(50)	50	407	CHAR(50)	DSS.T_PR_SVC_LOC_DN	NAM_PROVIDER	See logic for row 20 (Managed Care Plan ID) for how to locate the MCP provider name in the same manner.

Field Name	Field Description	Header Row Column Name	Output Field Length ***	Field Length including delimiter/EOR Marker	Starting Position (relative 1)	BIAR Source Data Type ***	BIAR Source Table	BIAR Source Field Name	BIAR Transformation Logic
TPL Coverage	Value will be a Y if the recipient currently has TPL coverage within the reporting period.	R_TPL	CHAR(5)	6	457	N/A	derived from DSS.T_TPL_RESOURCE	derived from SAK_RECIP	fill with trailing spaces  check to see if SAK_RECIP is on T_TPL_RESOURCE then using SAK_TPL_RESOURCE go against T_COVERAGE_XREF to see if at least one of the coverage codes eff dates fall witin your reporting period? Select count(*) From t_tpl_resource res, T_coverage_xref xref Where res.sak_recip = your sak_recip And res.sak_tpl_Resource = xref.sak_tpl_resource And xref.dte_effective <= report end period And xref.dte_end >= report start period; If count(*) > 0 then Y else N
Recipient Medicare Number	Recipient Medicare number	R-MedicareID	CHAR(12)	13	463	CHAR(12)	DSS.T_RE_HIB	ID_MEDICARE	
Medicare Part A Coverage	Value will be a Y if the recipient has Medicare Part A coverage.	R-PartA	CHAR(7)	8	476	N/A	derived from DSS.T_RE_MEDICARE_A	derived from SAK_RECIP	fill with trailing spaces  Move a Y if the SAK_RECIP is found on T_RE_MEDICARE_A table. Else, move N.
Medicare Part B Coverage	Value will be a Y if the recipient has Medicare Part B coverage.	R-PartB	CHAR(7)	8	484	N/A	derived from DSS.T_RE_MEDICARE_A	derived from SAK_RECIP	fill with trailing spaces  Move a Y if the SAK_RECIP is found on T_RE_MEDICARE_B table. Else, move N.
Medicare Part C Coverage	Value will be a Y if the recipient has Medicare Part C coverage.	R-PartC	CHAR(7)	8	492	CHAR(1)	DSS.T_RE_BASE_DN	IND_MEDICARE_C	fill with trailing spaces
Medicare Part D Coverage	Value will be a Y if the recipient has Medicare Part D coverage.	R-PartD	CHAR(7)	8	500	CHAR(1)	DSS.T_RE_BASE_DN	IND_MEDICARE_D	fill with trailing spaces
Asthma Diagnosis	Value will be a Y if the recipient had Asthma as a primary or secondary diagnosis on any paid claim during the reporting period; else, N	R-Diag1	CHAR(8)	9	508	N/A	derived from DSS.T_CA_DIAG_DN	derived from CDE_DIAG_1 or CDE_DIAG_2	fill with trailing spaces  Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Diabetes Diagnosis	Value will be a Y if the recipient had Diabetes as a primary or secondary diagnosis on any paid claim during the reporting period; else, N	R-Diag2	CHAR(8)	9	517	N/A	derived from DSS.T_CA_DIAG_DN	derived from CDE_DIAG_1 or CDE_DIAG_2	fill with trailing spaces  Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Coronary Artery Disease Diagnosis	Value will be a Y if the recipient had Coronary Artery Disease as a primary or secondary diagnosis on any paid claim during the reporting period; else, N	R-Diag3	CHAR(8)	9	526	N/A	derived from DSS.T_CA_DIAG_DN	derived from CDE_DIAG_1 or CDE_DIAG_2	fill with trailing spaces  Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Hypertensive Disease Diagnosis	Value will be a Y if the recipient had Hypertensive Disease as a primary or secondary diagnosis on any paid claim during the reporting period; else, N	R-Diag4	CHAR(8)	9	535	N/A	derived from DSS.T_CA_DIAG_DN	derived from CDE_DIAG_1 or CDE_DIAG_2	fill with trailing spaces  Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Bipolar Diagnosis	Value will be a Y if the recipient had Bipolar as a primary or secondary diagnosis on any paid claim during the reporting period; else, N	R-Diag5	CHAR(8)	9	544	N/A	derived from DSS.T_CA_DIAG_DN	derived from CDE_DIAG_1 or CDE_DIAG_2	fill with trailing spaces  Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Chronic Obstructive Pulmonary Disease Diagnosis	Value will be a Y if the recipient had Chronic Obstructive Pulmonary Disease as a primary or secondary diagnosis on any paid claim during the reporting period; else, N	R-Diag6	CHAR(8)	9	553	N/A	derived from DSS.T_CA_DIAG_DN	derived from CDE_DIAG_1 or CDE_DIAG_2	fill with trailing spaces  Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.

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Congestive Heart Failure Diagnosis	Value will be a Y if the recipient had Congestive Heart Failure as a primary or secondary diagnosis on any paid claim during the reporting period; else, N	R-Diag7	CHAR(8)	9	562	N/A	derived from DSS.T_CA_DIAG_DN	derived from CDE_DIAG_1 or CDE_DIAG_2	fill with trailing spaces Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Obesity Diagnosis	Value will be a Y if the recipient had Obesity as a primary or secondary diagnosis on any paid claim during the reporting period; else, N	R-Diag8	CHAR(8)	9	571	N/A	derived from DSS.T_CA_DIAG_DN	derived from CDE_DIAG_1 or CDE_DIAG_2	fill with trailing spaces Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Schizophrenia Diagnosis	Value will be a Y if the recipient had Schizophrenia as a primary or secondary diagnosis on any paid claim during the reporting period; else, N	R-Diag9	CHAR(8)	9	580	N/A	derived from DSS.T_CA_DIAG_DN	derived from CDE_DIAG_1 or CDE_DIAG_2	fill with trailing spaces Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Nicotine Dependency Diagnosis	Value will be a Y if the recipient had Nicotine Dependency as a primary or secondary diagnosis on any paid claim during the reporting period; else, N	R-Diag10	CHAR(8)	9	589	N/A	derived from DSS.T_CA_DIAG_DN	derived from CDE_DIAG_1 or CDE_DIAG_2	fill with trailing spaces Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Utilization Category 1 - # ER Visits	This value will be a count of ER visits for the recipient for the reporting period	R-Util1	NUMBER(10)	11	598	N/A	derived	derived	filling with leading zeroes Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Utilization Category 2 - # Hospital Inpatient Admissions - psychiatric	This value will be a count of hospital inpatient admissions-psychiatric for the recipient for the reporting period	R-Util2	NUMBER(10)	11	609	N/A	derived	derived	filling with leading zeroes Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Utilization Category 3 - # Hospital Inpatient Admissions - non-psychiatric	This value will be a count of hospital inpatient admissions-non-psychiatric for the recipient for the reporting period	R-Util3	NUMBER(10)	11	620	N/A	derived	derived	filling with leading zeroes Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Utilization Category 4 - # Physician Visits	This value will be a count of primary care visits for the recipient for the reporting period	R-Util4	NUMBER(10)	11	631	N/A	derived	derived	filling with leading zeroes Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.
Utilization Category 5 - # Behavioral Health Visits	This value will be a count of Behavioral health visits for the recipient for the reporting period	R-Util5	NUMBER(10)	11	642	N/A	derived	derived	filling with leading zeroes Reference the 'Criteria for Inclusion' tab of this spreadsheet for details on the criteria for populating this field.

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\*\*\*The Output Field Length could be different from the BIAR Source Data Type to accommodate for the number of bytes for the value in the Header Row Column Name.

--This extract will be transmitted from HP to ODJFS via SFTP using TIBCO and Connect Direct. ODJFS will distribute the extract to the providers.

The following are details on the formatting of the file:

--This file will be a fixed file length with both field lengths being fixed and the overall file length being fixed.

--It will be delimited file with the delimiter between the fields being a tilde ~

--The format will be ASCII.

--Numbers (noted with a BIAR Source Data Type of NUMBER) will be right justified with leading zeroes

--Character fields will be left justified with trailing spaces.

--The end of record delimiter will be Hex 'OA'.

\* This extract will be generated as a one-time extract at the start of the Health Home project in production (as of 7/27/2012, that date was 10/01/2012).

\* A list of Health Home provider Medicaid IDs and associated Recipient Medicaid IDs will be provided to HP in an Excel spreadsheet format.

\* HP will then use that information to generate the Health Home Patient Profile-Recipient Demographic and Health Summary extract for each provider's list of recipients.

\* Below is the criteria for the Utilization Categories and Specific Diagnosis categories.

**NOTE: The following evaluations will be performed against a recipient's claim. The evaluations are actually performed during the evaluations for the Health Home Patient Profile-Claims extract to determine if a 'Y' should be moved to the appropriate Diagnosis field on the Health Home Patient Profile-Recipient Demographic and Health Summary extract.**

### **Asthma Diagnosis**

Evaluate all of a recipient's claims meeting the following criteria:

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Primary or Secondary Diagnosis Code on the claim is equal to any of the following:
  - 4930x
  - 4931x
  - 4938x
  - 4939x

If the above criteria is met on at least one claim, move a 'Y' to the Asthma Diagnosis field on the Health Home Patient Profile-Recipient Demographic and Health Summary extract.

### **Diabetes Diagnosis**

Evaluate all of a recipient's claims meeting the following criteria:

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Primary or Secondary Diagnosis Code on the claim is equal to any of the following:
  - 250xx
  - 3572
  - 3620x
  - 36641
  - 6480x

If the above criteria is met on at least one claim, move a 'Y' to the Diabetes Diagnosis field on the Health Home Patient Profile-Recipient Demographic and Health Summary extract.

### **Coronary Artery Disease Diagnosis**

Evaluate all of a recipient's claims meeting the following criteria:

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Primary or Secondary Diagnosis Code on the claim is equal to any of the following:
  - 41000-41399
  - 4140x
  - 4142x
  - 4148x
  - 4149x

If the above criteria is met on at least one claim, move a 'Y' to the Coronary Artery Disease Diagnosis field on the Health Home Patient Profile-Recipient Demographic and Health Summary extract.

### **Hypertensive Disease Diagnosis**

Evaluate all of a recipient's claims meeting the following criteria:

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Primary or Secondary Diagnosis Code on the claim is equal to any of the following:
  - 40100-40599

If the above criteria is met on at least one claim, move a 'Y' to the Hypertensive Disease Diagnosis field on the Health Home Patient Profile-Recipient Demographic and Health Summary extract.

### **Bipolar Diagnosis**

Evaluate all of a recipient's claims meeting the following criteria:

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Primary or Secondary Diagnosis Code on the claim is equal to any of the following:
  - 2960x
  - 2961x
  - 2964x
  - 2965x
  - 2966x
  - 2967x
  - 2968x
  - 30113

If the above criteria is met on at least one claim, move a 'Y' to the Bipolar Diagnosis field on the Health Home Patient Profile-Recipient Demographic and Health Summary extract.

### **Chronic Obstructive Pulmonary Disease**

Evaluate all of a recipient's claims meeting the following criteria:

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Primary or Secondary Diagnosis Code on the claim is equal to any of the following:
  - 491xx
  - 492xx
  - 496xx
  - 5064x

If the above criteria is met on at least one claim, move a 'Y' to the Chronic Obstructive Pulmonary Disease Diagnosis field on the Health Home Patient Profile-Recipient Demographic and Health Summary extract.

### **Congestive Heart Failure Diagnosis**

Evaluate all of a recipient's claims meeting the following criteria:

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Primary or Secondary Diagnosis Code on the claim is equal to any of the following:
  - 4280x

If the above criteria is met on at least one claim, move a 'Y' to the Congestive Heart Failure Diagnosis field on the Health Home Patient Profile-Recipient Demographic and Health Summary extract.

### **Obesity Diagnosis**

Evaluate all of a recipient's claims meeting the following criteria:

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Primary or Secondary Diagnosis Code on the claim is equal to any of the following:
  - 27800
  - 27801
  - 6491x

If the above criteria is met on at least one claim, move a 'Y' to the Obesity Diagnosis field on the Health Home Patient Profile-Recipient Demographic and Health Summary extract.

### **Schizophrenia Diagnosis**

Evaluate all of a recipient's claims meeting the following criteria:

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Primary or Secondary Diagnosis Code on the claim is equal to any of the following:
  - 295xx

If the above criteria is met on at least one claim, move a 'Y' to the Schizophrenia Diagnosis field on the Health Home Patient Profile-Recipient Demographic and Health Summary extract.

### **Nicotine Dependency Diagnosis**

Evaluate all of a recipient's claims meeting the following criteria:

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Primary or Secondary Diagnosis Code on the claim is equal to any of the following:
  - 3051x
  - 6490x
  - 98984

If the above criteria is met on at least one claim, move a 'Y' to the Nicotine Dependency Diagnosis field on the Health Home Patient Profile-Recipient Demographic and Health Summary extract.

### **Utilization Category 1 - # ER Visits**

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Claim Type equal to 'O' (Outpatient) or 'C' (Outpatient Crossover)
  - If FFS, Type of Bill on the claim is equal to '0131' AND Procedure Code on the claim is within the range of 99281-99285
  - If Encounter, Type of Bill on the claim is equal to '0131' AND
    - Procedure Code on the claim is within the range of 99281-99285
    - OR Revenue Code on the claim is equal to 045xx, 0981

**Utilization Category 2 - # Hospital Inpatient Admissions - Psychiatric**

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Claim Type equal to 'I' (Inpatient) or 'A' (Inpatient Crossover)
- Primary Diagnosis Code on the claim is within the range of 29000-31999

**Utilization Category 3 - # Hospital Inpatient Admissions - Non-Psychiatric**

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Claim Type equal to 'I' (Inpatient) or 'A' (Inpatient Crossover)
- Primary Diagnosis Code on the claim is NOT within the range of 29000-31999

#### **Utilization Category 4 - # Physician Visit Information**

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Claim Type equal to 'M' (Professional) or 'B' (Professional Crossover)
- Rendering Provider Type and Rendering Provider Specialty on the claim is equal to any of the combinations below:
  - Provider Type 04, Provider Specialty 040
  - Provider Type 12, Provider Specialty 121
  - Provider Type 20, Provider Specialty any value
  - Provider Type 50, Provider Specialty 500, 501
  - Provider Type 65, Provider Specialty 650, 651
  - Provider Type 72, Provider Specialty 207, 212, 216, 651, 720
- Procedure Code on the claim is equal to any value within the following ranges below:
  - Office and other outpatient services: 99201-99215
  - Office and other outpatient consultations: 99241-99245
  - Domiciliary, rest home, or custodial services: 99324-99337
  - Domiciliary, rest home, or home care plan oversight services: 99339-99340
  - Home Services: 99341-99350
  - Case Management Services, anticoagulant management: 99363-99364
  - Medical Team Conferences: 99366-99368
  - Care Plan Oversight: 99374-99380
  - Preventive Medicine Services: 99381-99429
  - Non face to face physician services: 99441-99442
  - Medicine range of Psychology codes:90804-90899

#### **Utilization Category 5 - Behavioral Health Visits**

- Fee-for-Service and Encounters
- Latest Claims Only
- Claim Detail Status Code is equal to Paid
- Payment Date on the claim is within 24 months of the current system date
- Claim Type equal to 'M' (Professional) or 'B' (Professional Crossover)
- From Date of Service on the claim is greater than or equal to 07/01/2012
- Rendering Provider Type and Rendering Provider Specialty on the claim is equal to any of the combinations below:
  - Provider Type 04, Provider Specialty 042
  - Provider Type 51, Provider Specialty 511, 512
  - Provider Type 65, Provider Specialty 213
  - Provider Type 72, Provider Specialty 213
  - Provider Type 84, Provider Specialty any value

R_MedicaidID	~	R-First Name	~	R-MI	~	R-Last Nm	~	R-Street1	~
999999999999	~	JANE	~	A	~	DOE	~	123 STREET	~

R-Street2  
RTE 1

~  
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