**Addendum I – Supplemental Application**

**Colorado All Payer Claims Database Application**

**Project Description and Data Objective**

Project Title and number: *(matches Project Title on CO APCD Application)*

**Date Range or Years Requested** – *What years of claims do you need to meet your project purpose? (If you want a range of data with specific month and day start and end dates, please supply the start and end dates next to the appropriate year.)*

Check all that apply:

**[ ]** 2009\*

[ ]  2010\*

[ ]  2011\*

[ ]  2012

[ ]  2013

[ ]  2014

[ ]  2015

[ ]  2016

[ ]  2017

**Medicare FFS data:** Data requests are only available for research purposes and must be approved and financially supported by HCPF.

Check all that apply:

**[ ]** 2009\*

[ ]  2010\*

[ ]  2011\*

[ ]  2012

[ ]  2013

[ ]  2014

[ ]  2015

\***Please Note:** Data available from 2009-2011 is less robust than 2012-current. Please contact your Account Executive if you have questions.

**Lines of Business:** *Which payers do you need for your project purpose?*

Please check all that apply

**[ ]  Commercial Payer Claims** - Data available with appropriate levels of aggregation

Need to discuss appropriate level of aggregation for client request type; would need analyst input

**[ ]  Individual**

**[ ]  Small Group Plans**

**[ ]  Large Group Plans**

* + - ***Currently available:*** Medical Claims AND Pharmacy Claims from 2009- June 2017
			* **Claims**
			* **Eligibility**
			* **Servicing and Billing Provider information**

[ ]  **Fully insured Employer Plans**

**[ ]  Self-Insured ERISA and non-ERISA based Employer Plans (note: ERISA-based plans are voluntary submitters and are not all represented in the CO APCD)**

* + - ***Currently available:*** Medical Claims AND Pharmacy claims from 2015- June 2017
			* **Claims**
			* **Eligibility**
			* **Servicing and Billing Provider information**

**[ ]  Medicare Advantage** - data is available with appropriate levels of aggregation

Need to discuss appropriate level of aggregation for client request type; would need analyst input

* + - ***Currently available:*** Medical AND Pharmacy claims from 2015- June 2017
			* **Claims**
			* **Eligibility**
			* **Servicing and Billing Provider information**

**[ ]  Health First Colorado (Colorado’s Medicaid Program)** - Data requests must be reviewed by the Colorado Department of Health Care Policy and Financing (HCPF) to ensure alignment with administration of the Medicaid program as required by federal law

* + - ***Currently available:*** Medical Claims AND Pharmacy Claims from 2009- February 2017
			* **Claims**
			* **Eligibility**
			* **Servicing and Billing Provider information**

**The following lines of business, when requested, require CIVHC Data Release Review Committee review as well as HCPF review, approval, and financial support.**

**[ ]  Medicare Fee For Service (FFS) -** Data requests are only available for research purposes and must be approved and financially supported by HCPF.

* + - ***Currently available:*** Medical Claims AND Pharmacy Claims from 2009-2015
			* **Claims**
			* **Eligibility**
			* **Servicing and Billing Provider information**

**Payer-Specific Details** – Do you need to limit claims to particular health insurance coverage types?

**[ ]  Yes**

**[ ]  No**

* **If YES,** please indicate the specific information you would like to include:
	+ **Payer Line of Business**

**[ ]  Commercial**

* + - * **Payer Name: Please note Anti-trust guidelines will be followed. (DRRC review maybe also be required)**
				+ *Please provide listing of payer names and health plans*
			* **Commercial Product Line(s):**

**[ ]  PPO**

**[ ]  HMO**

**[ ]  POS**

**[ ]  Supplemental**

**[ ]  Indemnity**

**[ ]  Other- Please specify**

* *Please provide listing of other product lines*

**[ ]  Colorado’s Exchange, Connect for Health Colorado, Product Lines**:

**[ ]  Gold**

**[ ]  Silver**

**[ ]  Bronze**

**Payment Type** – *Which elements of total paid amount on each claim do you need to support your project purpose? (Check all that apply)*

**[ ]  Charged Amount**

**[ ]  Plan Paid Amount\***

**[ ]  Member Liability, i.e., amount the member is responsible for (check all that apply)**

**[ ]  Coinsurance**

**[ ]  Deductible**

**[ ]  Copay**

**[ ]  Total Allowed Amount** – (summation of plan paid and member liability)

**[ ]  Prepaid Amount** – (*to be considered for capitated payment plans only*)

**Medical Claims** – *Which types of claims do you need for your project purpose?*

* Check all that apply

**[ ]  Inpatient (IP)** – Related to individuals who receive care in hospital settings

**[ ]  Outpatient (OP)** – Related to an individual receiving medical treatment in any setting other than a hospital admission (i.e. ambulatory surgery center; doctor’s office, imaging center, Emergency Room, home health, etc.)

**[ ]  Professional (PROF)** – Related to medical procedures within professional settings (e.g. physician office, imaging center, etc.) and clinics

**Pharmacy Claims** – *Do you need prescription drug-based claims for your project purpose?*

**[ ]  Yes**

**[ ]  No**

* **If YES**, and you need pharmacy claims limited to specific drug types, ***please list the 11-digit NDC codes you would like to receive (DO NOT INCLUDE DASHES AND PROVIDE LEADING ZEROS):***
	+ - *Please provide listing*

**Dental Claims** – *Do you need dental claims for your project purpose?*

[ ]  **Yes**

**[ ]  No**

**Site of Service Detail** – *Do you need to look at claims that occurred in specific care settings for your project purpose? i.e., do you need to limit services by site of service?*

**[ ]  Yes**

**[ ]  No**

* **If YES,** please indicate the specific information you would like to include:

**[ ]  Hospital**

**[ ]  Ambulatory Surgery Centers**

**[ ]  Outpatient Facilities**

**[ ]  Physician offices**

**[ ]  Specialty offices**

**[ ]  Home Health**

**[ ]  Urgent Care**

**[ ]  Emergency Room (Note: cannot differentiate between majority of Free-Standing and hospital-based ERs)**

**[ ]  Other** (specify)

* + - *Please list other site of service details*

**Provider-level Detail** – *Do you need claims limited to specific providers or provider type(s) ie. (Provider IDs, locations, hospitals, medical groups, etc.) for your project purpose?*

**[ ]  Yes**

**[ ]  No**

* **If YES,** please indicate the specific provider types you would like to include or provide a list of providers:

**[ ]  Facilities (hospitals, ambulatory surgery centers, etc.)**

* + - *Please provide listing*

**[ ]  Professionals**

* + - *Please provide listing*

**[ ]  Provider Taxonomy** - **Specialty Designations**

* + - *Please provide listing*

**[ ]  National Provider Identifier**

* + - *Please provide listing*

**[ ]  Other**

* + - *Please provide listing*

**Geography**– *Do you need claims data limited by geography or location for your project purpose?*

**[ ]  Yes**

**[ ]  No**

* **If YES,** please indicate the geographic groupings you would like to include:

**[ ]  Provider location address**

* + - *Please provide listing*

**[ ]  Member location address**

* + - *Please provide listing*

**[ ]  Zip 3**

* + - *Please provide listing*

**[ ]  Health Statistic Region**

<http://www.cohid.dphe.state.co.us/brfssdata.html>

* + - *Please provide listing*

**[ ]  County (Potential PHI)**

* + - *Please provide listing*

**[ ]  Zip 5** (**PHI**)

* + - *Please provide listing*

**[ ]  Other**

* + - *Please provide listing*

**Age and/or Gender** – *Do you need claims data limited by age or gender for your project purpose?*

**[ ]  Yes**

**[ ]  No**

* **If YES,** please indicate the groupings you would like to include:

**[ ]  Age bands/range (in years) requested (i.e. 0-21, 22-39, 40-55, etc.)**

*Please specify specific bands and/or ranges*

*Please specify how you would like age to be calculated (i.e. Patient age at the end of year, at the time of service, etc.)*

**[ ]  Gender**

**[ ]  Male**

**[ ]  Female**

**[ ]  Unspecified**

**Member-level Detail** – *Do you need claims filtered at the member level for your project purpose?* *i.e.,* *do you need claims limited to specific members for your project?*

**[ ]  Yes**

**[ ]  No**

* **If YES,** please indicate the information you would like to include:

**[ ]  De-identified member information**

**[ ]  Unique member and person ID**

**[ ]  Gender**

**[ ]  Age: (at time of service)**

**[ ]  3-digit zip**

**[ ]  Protected Health Information (PHI)** – Any of the below requires DRRC approval process

**[ ]  Names (first, last, middle) (PHI)**

**[ ]  Street Address (PHI)**

**[ ]  City (PHI)**

**[ ]  Zip (PHI)**

**[ ]  DOB (PHI)**

**Diagnosis Detail** – *Do you need claims limited to a specific diagnosis or multiple diagnoses for your project purpose?*

**[ ]  Yes**

**[ ]  No**

* **If YES,** please indicate the specific diagnosis code(s) you would like to include (DO NOT USE DECIMAL POINTS AND DO NOT REMOVE LEADING AND TRAILING ZEROS):
	+ *Please provide listing*

**Procedure/Revenue Code Detail** – *Do you need claims limited to specific procedure or revenue code(s) for your project purpose?*

**[ ]  Yes**

**[ ]  No**

* **If YES,** please indicate the specific procedure/revenue code(s) you would like to include under each type requested:

**[ ]  CPT4**

*Please provide listing*

**[ ]  CDT**

*Please provide listing*

**[ ]  Revenue code**

*Please provide listing*

**[ ]  APR-DRG**

*Please provide listing*

**[ ]  ICD9 or ICD10**

**(Please indicate whether the codes you provide are ICD 9 or 10 codes)**

*Please provide listing*

**Additional Requests/Info Not Included Above**– *Is there any additional information you would like for us to know to fulfill your request?*

* *Please list additional request for information below.*