ATTACHMENT M: NETWORK PRICING SUBMISSION FORMAT SAMPLE

Provider Tax ID (TIN)	Provider Zip Code	Provider Name	Provider Last Name	Provider First Name	Provider Street Address	Provider City	Provider State	Date Of Service Start	Date Of Service End	Service Type	Place of Service	Provider Specialty Code	Procedure Code	Procedure Modifier	Revenue Code	Hospital DRG	Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 2	Claim ID	Medicare Indicator	Usual Customary Reasonable / Maximum Allowed Charge	Billed Charges	Amount Paid by Medicare	Allowed Charges	Network Code	Provider Contract Type
111948752	**72635**	MARY KAY	KAY	MARY	123 ANY STREET	CASSVILLE	AR	20090210	20090210	AN	24	A0	00142	QZ			366.19	401.9	491.21	090518P13ZT4	Y	500	488.25	99.74	124.68	1	

Responses should be provided in a comma-delimited text file format.

The un-shaded columns show the claims data provided on CD by EBD.
The shaded columns show the information that must be provided by the Prospective Contractor for each claim.

Information/Pricing for each claim **must** be formatted as above with one horizontal row for each claim on the spreadsheet.
Column width may be expanded as data necessitates.