APCD COUNCIL All-Payer Claims Database
A program of NAHDO in partnership with the University of New Hampshire

Institute for Health Policy and Practice

NCP Data Layout™

A DATA LAYOUT FOR NON-CLAIMS PAYMENTS

Maintained by APCD Council
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Acknowledgements

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Overview

All-Payer Claims Databases (APCDs) are large-scale databases that systematically collect healthcare payment data from the existing systems created to reimburse providers. APCDs exist as statewide, comprehensive databases managed by a state agency or its designee. APCDs are also created voluntarily for a region or specific stakeholders within a state, usually by nonprofit organizations such as healthcare-related employer business groups or community coalition organizations.

State agencies, employers, providers, consumers, health plans, and other researchers use APCDs for many purposes including, but not limited to:

- Examining healthcare cost, utilization, quality, and outcomes,
- Promoting transparency of healthcare costs,
- Evaluating value-based purchasing,
- Designing wellness programs,
- Trending and benchmarking.

These use cases inform APCD design. Most are structured to create a single de-identified person identifier across payers to create a longitudinal record of services rendered and all provider reimbursements without duplication.

Purpose

The files in this guidance can be used to collect non-claims payment (NCP) data not captured by using the APCD Common Data Layout (APCD-CDL™).[1] This layout aims to harmonize NCP data collection efforts across states and reduce the burden of data submission. The overall goals of this effort are to improve efficiency, reduce administrative costs, and improve accuracy in healthcare payment data.

States determine submission requirements, such as the scope of plans required to submit and which files are required, member inclusion criteria, submission frequency, and due dates, including how much run-out will be allowed and whether to refresh previous years' data.

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[1] *APCD Common Data Layout Version 3.0.1*, APCD Council, NAHDO and University of New Hampshire, April 2023, https://www.apcdcouncil.org/sites/default/files/media/2023-09/apcd-cdl-v3.0.1_errata_public.pdf (accessed April 2024).

Technical Specifications

FILE CONTENT

This layout contains numbered data elements with a data type, maximum length, and description, often including valid values, for collecting non-claims payment data from healthcare payers and pharmaceutical manufacturers.

Variations from any file layout can cause data processing delays and errors, requiring additional resources to bring non-compliant submissions into the APCD. Therefore, exceptions should only be granted when data submitter compliance is unfeasible. Programs typically only give exceptions for the shortest time possible.

This guidance is intentionally silent on establishing 1) definitions for "primary care" and "behavioral health" and 2) data quality thresholds to allow states flexibility during testing and implementation. Both will vary across state-designated agencies due to policy and technical capability differences. Care definitions and data quality can also vary by data supplier within a state. For this reason, states typically establish data quality thresholds based on submission testing, expectations setting with data suppliers, and in consultation with other state agencies collecting these data. Exceptions to data quality thresholds might be negotiated and adjusted over time to improve data quality in compliance with submission requirements.

Financial Amounts

Financial amount data elements assume the following:

- The amount paid for each payment record is mutually exclusive.
- For non-claims payment records (i.e., annual, pharmacy rebates, and capitation), round or truncate to the nearest dollar and report as an integer.

Payment Categories

The California Department of Health Care Access and Information (HCAI) and Freedman HealthCare LLC developed the Expanded Non-Claims Payment Framework (or Expanded Framework) in consultation with Bailit Health, the author of a Millbank Memorial Fund paper

categorizing non-claims primary care spending.[2,3] This guidance adds to the Expanded Framework two values for capturing the fee-for-service payments and the member count.

NON-CLAIMS PAYMENT DATA LAYOUT

Annual Payment File (AP)

This file accommodates data on contractually based non-claims payments made by a payer to a provider.

Pharmacy Rebate (PR)

This file accommodates data on prescription drug rebate payments. “Pharmacy rebates” means payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system for drugs identified using the National Drug Code (NDC) labeler and product codes.

Capitation File (CF)

This file accommodates data on payments made by a payer to a provider for member-attributable services under a capitation arrangement.

FROM APCD-CDL™

Header and Trailer Records

Each annual payment, pharmacy rebate, and capitation file submission must contain header and trailer records. The header record is the first row of each separate file submission, and the trailer record is the last. The layout of the header and trailer records should match those in the APCD-CDL™.[4]

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[2] V. Pegany, M. Brandt, N. Tran, M. Valle, and C. Krawcyzk, *A New Standard for Categorizing and Collecting Non-Claims Payment Data,* March 2024, https://www.milbank.org/2024/03/a-new-standard-for-categorizing-and-collecting-non-claims-payment-data/ (accessed April 2024).

[3] E. Taylor, M. Bailit, and D. Kanneganti, *Measuring the Prevalence and Drivers of Non-Claims-Based Care in Commercially Insured Populations*, Milbank Memorial Fund, April 2021, https://www.milbank.org/wp-content/uploads/2021/04/Measuring_Non-Claims_7-1.pdf (accessed April 2024).

[4] *APCD Common Data Layout Version 3.0.1*, APCD Council, NAHDO and University of New Hampshire, April 2023, https://www.apcdcouncil.org/sites/default/files/media/2023-09/apcd-cdl-v3.0.1_errata_public.pdf (accessed April 2024).

Member Eligibility File (ME)

Users should reference the member eligibility file in the APCD-CDL™. The eligibility file is only relevant to the Capitation File but is necessary for member-attributable payments. It may not need to be submitted more than once.

Consistent Inter-file Identifier

Providing a consistent person identifier across files for all members, providers, and plans is critical. A data submitter and any contracted entity acting on their behalf shall ensure that member identifiers for the same individuals are unique and consistent across capitation and member eligibility files.

ANNUAL PAYMENTS (AP) FILE

ANNUAL PAYMENTS FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLAP001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLAP002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLAP003	Reporting Period Start Date	integer	6	YYYYMM. Beginning of reporting period covered for contract performance.
CDLAP004	Reporting Period End Date	integer	6	YYYYMM. End of reporting period covered for contract performance.
CDLAP005	Contract Number	varchar	80	The unique number identifying a contract between the submitter and the billing provider for the reported payment model.
CDLAP006	Contract Type	char	1	Use this field to indicate whether the payments reported were administered as part of a medical benefits contract or a dental benefits contract. The only valid codes for this field are: M = Medical: Payments made under a medical benefits contract, including all payments made to providers for medical, pharmacy, and dental services incurred under medical stand-alone coverage. D = Dental: Payments made under a dental benefits contract; this should include only payments made to providers for members on dental stand-alone coverage.

ANNUAL PAYMENTS FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLAP007	Billing Provider ID	varchar	35	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change.
CDLAP008	Billing Provider NPI	char	10	National Provider Identifier (NPI) for the billing provider as enumerated in the Center for Medicaid and Medicare Services National Plan & Provider Enumeration System (NPPES).
CDLAP009	Billing Provider Tax ID	char	9	Tax ID of the billing provider. Do not code punctuation.
CDLAP010	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.
CDLAP011	Billing Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave blank.
CDLAP012	Payment Category	char	1	A = Population health and practice infrastructure payments B = Performance payments C = Payments with shared savings and recoupments D = Capitation and full risk payments E = Other non-claims payments X = Fee for service Z = Member count Select a corresponding Payment Subcategory based on the initial character in the Payment Category.

ANNUAL PAYMENTS FILE				
Data Element #	Name	Type	Max Length	Description/Valid Values
CDLAP013	Payment Subcategory	char	2	A1 = Care management/care coordination/population health/medication reconciliation A2 = Primary care and behavioral health integration A3 = Social care integration A4 = Practice transformation payments A5 = EHR/HIT infrastructure payments B1 = Retrospective/prospective incentive payments: pay-for-reporting B2 = Retrospective/prospective incentive payments: pay-for-performance C1 = Procedure-related, episode-based payments with shared savings C2 = Procedure-related, episode-based payments with risk of recoupments C3 = Condition-related, episode-based payments with shared savings C4 = Condition-related, episode-based payments with risk of recoupments C5 = Risk for total cost of care (e.g., ACO) with shared savings C6 = Risk for total cost of care (e.g., ACO) with risk of recoupments D1 = Primary care capitation D2 = Professional capitation D3 = Facility capitation D4 = Behavioral health capitation D5 = Global capitation D6 = Payment to integrated, comprehensive payment and delivery systems X9 = Fee for service Z9 = Member count

ANNUAL PAYMENTS FILE				
Data Element #	Name	Type	Max Length	Description/Valid Values
CDLAP014	Member Count	int	12	The total number of members enrolled during the reporting period. Report when Payment Category (CDLAP012) = 'B', 'D', or 'Z': 1. Category = 'B': Total number of members associated with the incentive payments. 2. Category = 'D': Total number of members associated with the capitated payments reported. 3. Category = 'Z': Total number of months enrolled for members reported in Member Count (members for submitters entire book of business for the year). This record is not expected to have any dollar any associated dollar amounts reported.
CDLAP015	Member Months	int	12	Total number of members months during the reporting period, expressed in months of membership. Only report members for whom the data submitter is the primary payer. Report with Payment Category (CDLAP012) = 'B', 'D', or 'Z': 1. Category = 'B': Total number of members associated with the incentive payments. 2. Category = 'D': Total number of members associated with the capitated payments reported. 3. Category = 'Z': Total number of months enrolled for members reported in Member Count (members for submitters entire book of business for the year). This record is not expected to have any associated dollar amounts reported.
CDLAP016	Total Amount Paid/Allowed	int	12	Total of all payments made to the billing provider during the Reporting/Performance Period. For non-fee-for-service payments, this is the amount paid to the provider by the insurer. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.

ANNUAL PAYMENTS FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLAP017	Total Member Responsibility Amount	int	12	Total of all member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP018	Total Amount Paid for Primary Care	int	12	Total of all payments made to a billing provider for primary care services during the Reporting/Performance Period. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000. If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP019	Total Amount Paid for Behavioral Health	int	12	Total of all payments made to a billing provider for behavioral health services during the Reporting/Performance Period. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP899	Record Type	char	2	Value = AP

PHARMACY REBATES (PR) FILE

PHARMACY REBATE FILE				
Data Element #	Name	Type	Max Length	Description/Valid Values
CDLPR001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLPR002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLPR003	Reporting Period Start Date	integer	6	YYYYMM. Beginning of reporting period covered for contract performance.
CDLPR004	Reporting Period End Date	integer	6	YYYYMM. End of reporting period covered for contract performance.
CDLPR005	Drug Code - NDC Product Code	varchar	9	Report the National Drug Code (NDC) product code, which includes the first 8 or 9 digits and excludes the last one or two digits (package code) of the NDC. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. See Appendix H: External Code Source, United States Food and Drug Administration.
CDLPR006	Drug Manufacturer	varchar	50	Use this field to report the manufacturer of the drug.
CDLPR007	Drug Name	varchar	80	Use this field to report the text name of the drug.
CDLPR008	Brand/Generic Indicator	char	2	Indicates whether the drug itself is generic, not how the payer pays it. Valid codes are: 01=Branded drug 02=Generic drug

PHARMACY REBATE FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLPR009	Prescription Count	int	12	Number of prescription fills for each drug. Includes original prescriptions and refills.
CDLPR010	Member Count	int	12	Number of members filling a prescription during the reporting period.
CDLPR011	Total Paid Amount	int	12	Total of all payments made during the Reporting/Performance Period. Round to the nearest dollar (e.g., $1,000.25 converted to 1000. If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLPR012	Rebates Received	int	12	Report the total amount of the rebate received for the specified NDC code. Round to the nearest dollar (e.g., $1,000.25 converted to 1000. If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLPR899	Record Type	char	2	Value = PR

CAPITATION FILE (CF)

CAPITATION FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLCF001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLCF002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLCF003	Reporting Period Start Date	integer	6	YYYYMM. Beginning of reporting period covered for contract performance.
CDLCF004	Reporting Period End Date	integer	6	YYYYMM. End of reporting period covered for contract performance.
CDLCF005	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier/submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's/submitter's files for reporting and aggregation.
CDLCF006	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.
CDLCF007	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.
CDLCF008	Member Middle Initial	varchar	1	The member's middle initial. If the member is the subscriber, report the subscriber's middle initial.

CAPITATION FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLCF009	Member Sex	char	1	Sex of the member. M=Male F=Female U=UNKNOWN Member sex represents biological or administrative sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values).
CDLCF010	Member Date of Birth	date	8	Date of birth of the member. If the member is the subscriber, report the subscriber's date of birth. YYYYMMDD.
CDLCF011	Member Social Security Number	char	9	The member's Social Security Number. If the member is the subscriber, report the subscriber's Social Security Number. Do not include dashes. Leave blank if not collected.
CDLCF012	Billing Provider ID	varchar	35	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change.
CDLCF013	Billing Provider NPI	char	10	National Provider Identifier (NPI) for the billing provider as enumerated in the Center for Medicaid and Medicare Services National Plan & Provider Enumeration System (NPPES).
CDLCF014	Billing Provider Tax ID	char	9	Tax ID of the billing provider. Do not code punctuation.

CAPITATION FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLCF015	Billing Provider Last Name or Organization	varchar	60	Full name of provider billing organization or last name of individual billing provider.
CDLCF016	Billing Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave blank.
CDLCF017	Insurance/Product Category Code	char	2	See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choice available.
CDLCF018	Payment Subcategory	char	2	D1 = Primary care capitation D2 = Professional capitation D3 = Facility Capitation D4 = Behavioral health capitation D5 = Global capitation D6 = Payment to integrated, comprehensive payment and delivery systems
CDLCF019	Total Paid Amount	integer	12	Total of all payments made to a contractor during the Reporting/Performance Period. Round to the nearest dollar (e.g., $1,000.25 converted to 1000). This field may contain a negative value.
CDLCF899	Record Type	char	2	Value = CF

Appendix G1 - Insurance Type/Product Code

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-Fault Insurance including Insurance in which Auto Is Primary
15	Medicare Secondary Workers' Compensation
16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
17	Dental
18	Vision
19	Prescription Drugs (Commercial Coverage)
41	Medicare Secondary Black Lung
42	Medicare Secondary Veterans' Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Is Primary
AP	Auto Insurance Policy
C1	Other Commercial (Not Specified Elsewhere)
CO	Consolidated Omnibus Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
E	Medicare – Point of Service (POS)

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE

This is a list of codes used by state APCDs. To be used for claims and eligibility.

Code	Description
EP	Exclusive Provider Organization
FH	Federal Employees Health Benefits Program (HMO)
FP	Federal Employees Health Benefits Program (PPO)
FF	Family or Friends
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A (not to be used for commercial plans)
MB	Medicare Part B (not to be used for commercial plans)
MC	Medicaid
MD	Medicare Part D
MH	Medigap Part A
MI	Medigap Part B
MO	Medicare Advantage PPO
MP	Medicare Primary (not to be used for commercial plans)

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
MT	Medicaid CHIP
OT	Other
PE	Property Insurance – Personal
PL	Personal
PP	Personal Payment (Cash – No Insurance)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance – Real
SP	Supplemental Policy
S1	Medicare Special Needs Plan – Chronic Condition
S2	Medicare Special Needs Plan - Institutionalized
S3	Medicare Special Needs Plan – Dual Eligible
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
TR	Tricare
U	Multiple Options Health Plan
VA	Veterans Administration Plan
WC	Workers' Compensation
WU	Wrap Up Policy
11	Other Non-Federal Programs
DM	Dental Maintenance Organization

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE

This is a list of codes used by state APCDs. To be used for claims and eligibility.

Code	Description
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	CHAMPUS
CI	Commercial Insurance Company
LB	Liability
LM	Liability Medical
OF	Other Federal Program
TV	Title V
SL	Standalone limited (for example, vision only, hearing only)
ZZ	Mutually Defined (Use code ZZ when Type of Insurance is Unknown)

Appendix H - External Code Sources

APPENDIX H - EXTERNAL CODE SOURCES
Accredited Standards Committee (ASC) ASC X12 Directories SOURCE: PACDR Implementation Guides, ASC X12 005010 Standard AVAILABLE FROM: Data Interchange Standards Association, Inc. (DISA) 7600 Leesburg Pike Ste 430 Falls Church, VA 22043 http://store.x12.org/store Washington Publishing Company **http://www.wpc-edi.com/reference/** ABSTRACT: The PACDR Implementation Guides contain the descriptions of data elements used to construct X12 segments. The PACDR Guides also contain code lists associated with these data elements.
Centers for Medicare and Medicaid Services National Provider Identifier SOURCE: National Plan and Provider Enumeration System AVAILABLE FROM: Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244-1850 **https://nppes.cms.hhs.gov/** ABSTRACT: The Centers for Medicare and Medicaid Services developed the National Provider Identifier as the standard, unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

APPENDIX H - EXTERNAL CODE SOURCES

National Council for Prescription Drug Programs (NCPDP)

National Association of Boards of Pharmacy Number
SOURCE: National Association of Boards of Pharmacy Database and Listings
AVAILABLE FROM:
National Council for Prescription Drug Programs
9240 East Raintree Drive
Scottsdale, AZ 85260-7518
www.ncpdp.org

ABSTRACT: A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy Number is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

National Council for Prescription Drug Programs (NCPDP)

Uniform Healthcare Payer Data
SOURCE: NCPDP Uniform Healthcare Payer Data Standard Implementation Guide
AVAILABLE FROM:
National Council for Prescription Drug Programs
9240 East Raintree Drive
Scottsdale, AZ 85260
www.ncpdp.org

ABSTRACT: The Implementation Guide is intended to meet an industry need to supply detailed drug or utilization claim information from adjudicated claims that processors/payers or their clients report to States or their Agents.

National Uniform Billing Committee (NUBC)

NUBC Codes
SOURCE: National Uniform Billing Committee Official Data Specifications Manual
AVAILABLE FROM:
National Uniform Billing Committee American Hospital Association
155 N Wacker Drive
Chicago, IL 60606
www.nubc.org

APPENDIX H - EXTERNAL CODE SOURCES

National Uniform Claim Committee (NUCC)

Healthcare Provider Taxonomy Code Set
SOURCE: Washington Publishing Company
AVAILABLE FROM:
National Uniform Claim Committee
nuccinfo@nucc.org
http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

United States Food and Drug Administration (FDA)

National Drug Codes
SOURCE: National Drug Data File
AVAILABLE FROM:
U.S. Food and Drug Administration Center for Drug Evaluation and Research
Division of Data Management and Services
10903 New Hampshire Avenue
Silver Spring, MD 20993
www.fda.gov or **www.accessdata.fda.gov/scripts/cder/ndc/default.cfm**