Medicaid Unique BIN_PCN

RX BIN Number	RX PCN	RX Group	Line of Business	NCPDP Version	Effective as of
017142	ASPROD1	ML108	Medicaid	D.0	January 1, 2019
017142	ASPROD1	ML109	Medicaid	D.0	January 1, 2019
017142	ASPROD1	ML110	Medicaid	D.0	January 1, 2019
017142	ASPROD1	ML284	Medicaid	D.0	January 1, 2019
017142	ASPROD1	ML329	Medicaid	D.0	January 1, 2019

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1. NCPDP VERSION D CLAIM BILLING

1.1 GENERAL INFORMATION FOR PHARMACY PROCESSING

Payer Name: MedImpact Healthcare Systems - Commercial, Medicaid, MCO, Health Exchange Marketplace	Date: June 10, 2019	
Plan Name/Group Name: Various See Plan Profile Sheets	**BIN:** 003585, 005500, 005518 006053, 006631, 009224 011917, 012882, 013105 013113, 013675, 013709 014971, 014988, 015400 015441, 015517, 015525 015921, 016085, 016508 016516, 016549, 016671 016689, 016796, 017142 017168, 018050, 018596 018605, 020008, 020602 020750, 610193, 610312 610610, 610711, 808412	**PCN**: As specified on Plan Profile Sheets and/or ID cards
NOTE: BIN 015574 is the MedImpact Part D Bin. There is separate Part D Payer Sheet. Please refer to that for Part D submission requirements. **Additionally, if GOVERNMENT COB is required a separate Payer Sheet exists for that processing information.**		
Processor: MedImpact Healthcare Systems		
Effective as of: June 12, 2019	NCPDP Telecommunication Standard Version/Release #: D.Ø	
NCPDP Data Dictionary Version Date: August 2007	NCPDP External Code List Version Date: October 15, 2018	
Contact/Information Source:		
Certification Testing Window: 7/1/2011 – 12/31/2011		
Certification Contact Information:		
Provider Relations Help Desk Info:		
Other versions supported: None		

1.2 PROCESSING NOTES:

1.2.1 REVERSALS

Reversals must be submitted with the SAME Rx number as was submitted on the Original Paid Claim. This is per NCPDP transition guidance and should be noted by Pharmacies that are truncating Rx Numbers with 5.1 and plan to expand the size with D.0.

- Reversals must contain the Pharmacy ID, Rx Number, Date of Service and the reversal must meet all D.0 syntax requirements as noted in the "Formatting Rules" bullet below. These values on REVERSALS must mimic the values submitted on the originating CLAIM so 'matching' is possible.
- If more than one paid claim exists for the same combination noted above, the following are used as 'tie breakers' as necessary: Refill number, Other Coverage Code, Other Payer Coverage Type.
- Due to 4 RX Matching requirements, BIN, PCN, Cardholder Id and Group must be submitted as provided on original PAID claim.

1.2.2 REVERSALS OF COB CLAIMS

These should be performed in the correct "back out order" meaning LAST claim billed must be Reversed First until getting to the Primary Claim or a Claim to be re-submitted.

- If a claim has been billed as Primary, Secondary, Tertiary and the pharmacy wishes to re-process the Secondary claim, the Tertiary Claim must be reversed first, then the Secondary and then they can re-process the Secondary claim.
- The reversal of a COB claim beyond secondary should contain the COB Segment with Other Payer Coverage Type so in the instance that MedImpact is the payer of more than one claim for the Pharmacy, Rx, Date of Service and Fill number, the claim for reversal can be identified correctly.

1.2.3 TRANSACTION TYPES

Supporting B1 (Claim) and B2 (Reversal)

- B3 (REBILL) is NOT supported

1.2.4 ADDITIONAL DATA

MedImpact does not have plans to require MORE data fields than are noted in this document. Other features may be built out over time and a new Payer Sheet will be published. See Section indicated as REVISIONS in Table of Contents.

1.2.5 FORMATTING RULES

MedImpact is editing incoming data per guidelines of the NCPDP standard. Please note the following:

1.2.5.1 GENERAL RULES

- Lowercase values are not accepted
- We do NOT require Patient e-mail address (seeing this commonly sent as lower case)
- Gross Amount Due value must sum according to NCPDP formula
- If a field 'tag' is sent then something must be sent as the field value.
- If a Segment Id is sent, then some of the fields of that segment must also be submitted.
- All fields submitted are validated against format rules for that field (A/N, size, etc.)
- Cardholder Id - Trailing spaces are not allowed – the exact submission is used in Member lookup.
- Code values are validated against NCPDP ECL values
- Any field requiring a "Qualifier' must be preceded by the appropriate qualifier
- Any field that repeats must have the "Count" field precede it
- Reversals MUST include the Fill Number for matching to proper claim in case more than one fill per day was approved (i.e. vacation fill)
- Phone numbers must be 10 digits
- If any of the three Percentage Tax fields are submitted the other 2 fields are required.
- Zip Code fields are not to contain a Dash (see criteria for any Patient ZIP Code field in Data Dictionary.)
- DUR submissions must be ordered by the DUR counter field.

1.2.5.2 COORDINATION OF BENEFITS - COB

- If Other Coverage Code is 0 or 1 and a COB Segment is submitted this will cause a reject.
- If Other Coverage Code is 2 or greater a COB Segment is required
- Other Payer Patient Responsibility data is not allowed for Part D COB processing.

1.2.5.3 COMPOUNDS

- If Compound Code is 1 (Claim is NOT a Compound) and a Compound Segment is submitted this will cause a reject

- If Compound Code is 2 (Claim is a Compound) – the Compound Segment is required.;
- When Compound Segment is submitted, the Product/Service Id Qualifier must be 00 and Product Service Id must be 0 (one zero) per Implementation Guide
- Compound Ingredient Costs must sum to the Ingredient Cost in the Pricing Segment
- If a compound Ingredient cannot be identified, the claim will Reject with:
  Reject Code 54 (Non-Matched Product/Service ID Number)
  and will be accompanied by the Text Message:
  CLAIM COMPOUND DRUG nnnnn-nnnn-nn HAS INVALID NDC.
  - N's will be replaced with the invalid NDC submitted value
  - For valid products, pharmacy needs to request addition of the NDC by providing evidence of product in order for this to be added to the product file by FDB.

1.2.5.4 MEDICARE PART D ALLOWS FOR 1 TRANSACTION PER TRANSMISSION

- Please refer to Section 7 CLAIM BILLING OR ENCOUNTER INFORMATION of the NCPDP Implementation Guide to find the following:
  - "For Medicare Part D processing only one transaction per transmission is permitted because there is a need for the sequencing of the True Out Of Pocket (TrOOP) update before the next claim is processed. The TrOOP should be updated before subsequent claims are
  - Since our Bin 015574 is unique for Part D claims only please set your claim format to ONLY submit single transactions so pharmacy does not incur a reject for this reason.

1.3 REVISION HISTORY:

February 7, 2012	• correction to remove Bin 900002 from Bin listing on page 2
February 24, 2012	• clarification of Reversal requirements via bullets noted above • addition of SCHEDULED PRESCRIPTION ID NUMBER (454-EK) in CLAIM SEGMENT • clarification of value to use as OTHER PAYER ID (340-7C) in COB SEGMENT if Other Payer does not have a BIN due to offline billing.

March 1, 2012	• Clarification of tax fields in PRICING Segment:
	  • (481-HA) Flat Sales Tax Amount Submitted
	  • (482-GE) Percentage Sales Tax Amount Submitted

April 5, 2012	• Addition of Bin number 808412
April 18, 2012	• Addition of Bin number 900020

August 23, 2012	• Addition of Bin numbers: 610280, 016516, 016508, 015517
	• Removed references to 5.1 claims since no longer supported
	• Test system is no longer available
	• Included notation that B3 (Rebill) is not a Supported Transaction at this time.
	• Removed Supply designation from Scheduled Prescription Id for NYS Medicaid related claims.
	• For Prescriber validation, added 42Ø-DK Submission Clarification Code (values 42 – 46) approved for use as of July 1, 2012.
	• For CMS reporting, it is our recommendation at this point (may become required) that for Medicare Part D claims pharmacies submit appropriate values for the following fields:
	  ○ 384-4X Patient Residence
	  ○ 147-U7 Pharmacy Service Type

October 26, 2012	• Addition of Bin number 016549 • Removed response fields that are not presently supplied. Will add as usage becomes available.

	• Addition of ECL supported values for Oct 2012. Also including values to be supported as of Jan 1, 2013. CLAIM CLAIM SEGMENT 42Ø-DK Submission Clarification Codes 21 – 36; ~~47 & 48~~ for SCD (Short Cycle Dispensing) accepted as of Oct 2012 for processing starting Jan 1, 2013 Note 2012: SCC codes 47 and 48 were incorrectly listed and have been removed. These codes are not available for use until October 2013. COB SEGMENT 342-HC – Other Payer Amount Paid Qualifier value of 1Ø – Sales Tax 393-MV – Benefit Stage Qualifier – acceptance of codes 5Ø, 6Ø, 61, 62, 7Ø, 8Ø and 9Ø allowed however not presently used. TRANSMISSION ACCEPTED/CLAIM REJECTED RESPONSE RESPONSE STATUS SEGMENT 132-UH – Additional Message Information Qualifier value of 1Ø – Next Refill Date with format CCYYMMDD 548-6F – Approved Message Codes – reporting values Ø19 – Ø22 as required for Medicare Part D Prescriber Validation RESPONSE PRICING SEGMENT 393-MV – Benefit Stage Qualifier – reporting values Ø1 – Ø4 and 5Ø – 9Ø as required. • 61 and 62 will replace code value of 6Ø as of Jan 1, 2013. • 9Ø will not be used in responses until Jan 1, 2013
December 11, 2012 V2.11	Removed references to 5.1 in COB processing. • Clarified expectation that OCC 8 COB claims should be submitted with component parts that make up the Patient Pay Amount of the prior payer. • If component parts are not used, we are not able to determine when patient choice dollars were part of the value so rejection of an over dollar claim can occur. Removed SCC codes 46 and 47 that had been incorrectly added to the code list for Submission Clarification Code 420-DK. • Codes 46 and 47 are not available for use until October 2013. • Including 335-2C Pregnancy Indicator in Patient Segment
December 17, 2012 V2.12	419-DJ Prescription Origin Code - requesting value other than zero to be submitted for all claims – new or refill and all plan types – Part D, Medicaid, commercial. • While not all clients are requesting this, several are and will reject if data not submitted. 393-MV Benefit Stage Qualifier in COB Segment of claim submission – code of 6Ø lined out since no longer valid for Dates of Service after Jan 1, 2013 (as noted). 393-MV Benefit Stage Qualifier in Response Pricing Segment of claim response – code of 6Ø lined out since no returned for Dates of Service after Jan 1, 2013 (as noted).
January 17, 2013 V2.13	• Addition of Bin numbers 016085 and 016671 for Cash Card processing • Clarification that dash is not accepted on submission of any Zip code fields. Validation follows NCPDP data dictionary comment which indicates: "This left-justified field contains the five-digit zip code, and may include the four-digit expanded zip code in which the patient is located. Examples: If the zip code is 98765-4321, this field would reflect: 987654321.

	If the zip code is 98765, this field would reflect: 98765 left justified."
February 11, 2013 V2.14	• Addition of Bin number 016796 for Cash Card processing
February 26, 2013 V2.15	• Addition of Bin number 014971
September 15, 2013 V2.16	1) Clarification that dash is not accepted on submission of any Zip code fields. Validation follows NCPDP data dictionary comment which indicates: "This left-justified field contains the five-digit zip code, and may include the four-digit expanded zip code in which the patient is located. Examples: If the zip code is 98765-4321, this field would reflect: 987654321. If the zip code is 98765, this field would reflect: 98765 left justified." 2) Added field 429-Dt SPECIAL PACKAGING INDICATOR for Part D Short Cycle processing. If sent codes are validated. If not used per benefit set up, field is ignored. 3) Created a more robust Table of Contents CLAIM SUBMISSION CRITERIA 4) Guidance noted in Processing Notes above that Medicare Part D claims must be one Transaction per Transmission. 5) Addition of notation that the following fields will be REQUIRED for <u>all</u> Part D claims from ALL pharmacies starting Jan 1, 2014 • 384-4X Patient Residence • 147-U7 Pharmacy Service Type 6) 42Ø-DK Submission Clarification Code: Inclusion of values 47 and 48 for Jan 1, 2014 usage of related to Shortened Days Supply claims. 7) 423-DN Basis Of Cost Determination and 49Ø-UE Compound Ingredient Basis Of Cost Determination: Inclusion of code 14 for October 2013 usage 8) 492-WE Diagnosis Code Qualifier: removal of codes no longer supported as of Oct 2013: Ø6 - Medi-Span Product Line Diagnosis Code Ø8 - First DataBank Disease Code (FDBDX) Ø9 - First DataBank FML Disease Identifier (FDB DxID) 99 - Other 9) 475-J9 DUR Co-Agent ID Qualifier – removal of code no longer supported as of Oct 213 22 - Medi-Span Product Line Diagnosis Code The Additional Documentation Segment is NOT SUPPORTED by MedImpact processing and typically is IGNORED. However, some code values have been sunset or added and if this segment is submitted without valid values, the claim will reject. The Segment is NOT LISTED within the Claim Detail requirements that follow however are indicating the changes here. 10) 399-2Q Additional Documentation Type Id : removal of codes *no longer supported* as of Oct 2013: ØØ1 Medicare = Ø1.Ø2A Hospital Beds ØØ2 Medicare = Ø1.Ø2B Support Surfaces ØØ3 Medicare = Ø2.Ø3A Motorized Wheel Chair ØØ4 Medicare = Ø2.Ø3B Manual Wheelchair

	ØØ5 Medicare = Ø3.Ø2 Continuous Positive Airway Pressure (CPAP) Ø1Ø Medicare = Ø7.Ø2B Power Operated Vehicles (POV) Ø11 Medicare = Ø8.Ø2 Immunosuppressive Drugs Ø13 Medicare = 1Ø.Ø2A Parenteral Nutrition Ø14 Medicare = 1Ø.Ø2B Enteral Nutrition Addition of new codes Ø16 - Medicare 1Ø.Ø3 = Enteral and Parenteral Nutrition Ø17 - Medicare 11.Ø2 = Section C Continuation Form RESPONSE CRITERIA 11) 522-FM Basis Of Reimbursement Determination: Inclusion of codes 17 – 21 for use when applicable 12) 548-6F Approved Message Code: Change of verbiage for codes 18 – 22 Addition of codes 23 – 29 393-MV Benefit Stage Qualifier: Slight wording change to main text associated to code 61
December 17, 2013 *V2.17*	1) Addition of Health Exchange Marketplace as a Payer Type 2) Addition of 2 new Bins: 017142 – Medicaid, 017168 – Commercial
December 23, 2013 *V 2.18*	1) Addition of Bin number 006053 for ScriptSave transition to MedImpact
February 21, 2014 *V 2.19*	COB changes 1) Notation that MedImpact has select plans that require Government COB – see Payer Sheet named 'MedImpact D.0 Payer Sheet - Medicaid w/Government COB Processing" for processing details 2) For OCC 4 claims, 431-DV Other Payer Amount Paid with a Negative value is now accepted and will be treated as zero. This is per the NCPDP discussions and the upcoming sunset of Reject Code 8V - Negative Dollar Amount Is Not Supported In The Other Payer Amount Paid Field. Diagnosis Code criteria for October 1, 2014 3) 492-WE DIAGNOSIS CODE QUALIFIER Ø1 = ICD-9 – No longer allowed as of Oct 1, 2014 Ø2 = ICD-1Ø – as of Oct 1, 2014 4) 424-DO DIAGNOSIS CODE PER HIPAA STANDARD, DECIMAL POINT SHOULD NOT BE INCLUDED IN ICD-1Ø DIAGNOSIS CODE VALUES. From NCPDP ECL ICD-1Ø CODE SETS The International Statistical Classification of Diseases and Related Health Problems, 1Øth Revision (known as "ICD-1Ø") is maintained and copyrighted by the World Health Organization (WHO). On January 16, 2009 HHS published a final rule adopting ICD-10-CM (and ICD-10-PCS) to replace ICD-9-CM in HIPAA transactions, effective implementation date of October 1, 2013. The implementation of ICD-10 was delayed from October 1, 2013 to October 1, 2014 by final rule CMS-0040-F issued on August 24, 2012. Updates to this version of ICD-10-CM are anticipated prior to its implementation. The Clinical Modification ICD-1Ø-CM for diagnosis coding code set is available free of charge on the National Center for Health Statistics (NCHS) web site at http://www.cdc.gov/nchs/icd/icd1Øcm.htm.

	From the code set maintainer: The ICD codes do have a decimal; however, for transaction/submission of the codes the decimal is not included in the code. The reporting of the decimal between the third and fourth characters is unnecessary because it is implied. (Field is alphanumeric; count from left to right for the third and fourth characters.)
March 24, 2014 *V 2.20*	Bin Number change: • Removal of Bin 900020
October 3, 2014 *V 2.21*	Bin Number change: • Addition of Bin 013113 for ScriptSave Also added notation in COB Segment info that a SEPARATE Payer Sheet exists should Government COB be required. Support of appropriate ECL as relates to Reject Codes and Benefit Stage Values 393-MV Benefit Stage Qualifier – Added Code 63
October 7, 2014 *V 2.22*	492-WE - DIAGNOSIS CODE QUALIFIER • Accepting qualifier values for ICD-9 and ICD-10 and removed HIPAA implementation date.
January 1, 2015 *V2.23*	• New NCPDP reject code: '645' – Repackaged product is not covered by the contract • Update Coordination of Benefits section to indicate that Government COB is supported with select plans and that a separate Payer Sheet should be requested
February 19, 2015 *V2.24*	Bin Number change: • Removal of 3 Bins 010439, 610679, and 610182
June 17, 2015 *V2.25*	Bin Number change: • Add new Bin 011917
September 21, 2015 *V2.26*	• Added 42Ø-DK Submission Clarification Code values 50-52 • Added 548-6F Approved Message Code values 016,017, 030-033 • 424-DO DIAGNOSIS CODE PER HIPAA STANDARD, DECIMAL POINT SHOULD NOT BE INCLUDED IN ICD-1Ø DIAGNOSIS CODE VALUES. • New NCPDP reject codes: 30 - Reversal Request outside processor reversal window 31 - No Matching paid claim found for Reversal request 771 - Compound contains unidentifiable ingredient(s); Submission Clarification Code override not allowed 772 - Compound not payable due to non-covered ingredient(s); Submission Clarification Code override not allowed
February 22, 2016 *V2.27*	• Re-add Bin 018050
March 8, 2016 *V2.28*	• Updated 995-E2 Route of Administration • Added 474-8E DUR/PPS Level of Effort
June 6, 2016 *v2.29*	• Add new Bin 015921
June 17, 2016 *v 2.30*	Bin Number change: • Removed Bin 610280
June 30, 2016 *v2.31*	BIN Number change: • Add new Bin 018605
December 5, 2016 *v2.32*	BIN Number change: • Add new Bin 009224 • Updated emergency preparedness section with field EU
December 23, 2016 *v2.33*	BIN Number change: • Add new Bin 012882

January 10, 2017 *v2.34*	BIN Number change: • Add new Bin 006631
February 27, 2017 *v2.35*	BIN Number change: • Add new Bin 016689 • Removed Bin 610415
April 10, 2017 *v2.36*	Re-add Bin 006631

October 26, 2017
v2.37
	• Update Emergency Preparedness:
	  • Added SCC 13 for an override
	  • Patient address is not required
	
	• Update Submission Clarification Code (field 420-DK) - Payer Requirement: Value of '20' must be submitted when 340B drugs are dispensed to a Managed Medicaid and Fee-For-Service Medicaid members
	
	• Addition of ECL supported values for Oct 2017. Also including values to be supported as of Jan 1, 2018.
	
	CLAIM SEGMENT
	42Ø-DK Submission Clarification Codes - 55-56
	
	COB SEGMENT
	393-MV – Benefit Stage Qualifier – 51
	
	DUR/PPS SEGMENT
	474-8E DUR/PPS Level of Effort – 16-22
	
	RESPONSE STATUS SEGMENT
	548-6F – Approved Message Codes - 044, 045,046
	
	RESPONSE PRICING SEGMENT
	522-FM – Basis Of Reimbursement Determination - 23
	393-MV – Benefit Stage Qualifier - 51

November 29, 2017 *v2.38*	BIN Number change: • Add new Bin 018596
December 27, 2017 *v2.39*	BIN Number change: • Add new Bin 020008
April 30, 2018 *v2.40*	BIN Number change: • Add new Bin 610312
June 15, 2018 *v2.41*	BIN Number change: • Add new Bin 020602
November 15, 2018	• Added 42Ø-DK Submission Clarification Code values 57 • Update 402-DK Submission Clarification Code value 4 description • Update 548-6F Approved Message Code description for values 004-011,033 • Add 522-FM Basis of Reimbursement Determination values 16, 24 • Add 996-G1 Compound Type values 08,09,10,11 • Update 384-4X Patient Residence value 9 description • New 568-J7 Payer ID Qualifier value 05-Medicare Part D Contract Number • New 439-E4 Reason For Service HC – High Cumulative Dose – Detects high cumulative drug doses across multiple prescriptions that fall above the standard dosing range

	MP – Poly-Pharmacy Detected – Patient has obtained drugs in the same therapeutic class at multiple pharmacies with overlapping times frames MR - Poly-Prescriber Detected – Patient has obtained drugs in the same therapeutic class from multiple prescriber with overlapping times frames • New NCPDP reject codes: 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria 891 – Days Supply Less Than Plan Minimum 892 – Pharmacy Must Attest FDA REMS Requirements Have Been Met 893 – Pharmacy Must Attest Required Patient Form Is On File 894 – Pharmacy Must Attest Plan Medical Necessity Criteria Has Been Met 895 – Allowed Number of Overrides Exhausted 896 – Other Adjudicated Program Type Is Not Covered 922 – Morphine Equivalent Dose Exceeds Limits 923 – Morphine Equivalent Dose Exceeds Limits For Patient Age 924 – Cumulative Dose Exceeded Across Multiple Prescriptions 925 - Initial Fill Days Supply Exceeds Limits 926 – Initial Fill Days Supply Exceeds Limits for Patient Age 927 – Days Supply Limitation For Product/Service For Patient Age 928 – Cumulative Fills Exceeded Limits
March 28, 2019	BIN Number change: • Add new Bin 020750
June 10, 2019	• Update Emergency preparedness section – removed PA information • Update field 473-7E (DUR/PPS Code Counter) – removed wording about logic using only the first DUR iteration.

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Fields that are not used in the Claim Billing transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the template.

1.4 REQUEST CLAIM BILLING

1.4.1 CLAIM BILLING TRANSACTION

The following lists the segments and fields in a Claim Billing Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø.*

Transaction Header Segment Questions	Check	Claim Billing
This Segment is always sent	X	MANDATORY SEGMENT
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Claim Billing
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	See Bins listing on page 2	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	

	Transaction Header Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø4-A4	PROCESSOR CONTROL NUMBER	As specified on Plan Profile Sheets and/or ID cards	M	
1Ø9-A9	TRANSACTION COUNT	1 through 4 supported. Compounds and Part D per DØ standard can ONLY be 1 transaction per transmission	M	• Non Part D – up to 4 transactions • If Compound Segment is submitted, only 1 transaction is allowed per Imp Guide. Transmission will reject if count does not equal 1 and any transaction contains a compound segment. • Part D - 1 transaction per transmission in compliance with Imp Guide. Transmission will reject if count does not equal 1 and transaction is related to a Part D claim.
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 - NPI	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blanks	M	

Insurance Segment Questions	**Check**	**Claim Billing** **If Situational, *Payer Situation***
This Segment is always sent	X	MANDATORY SEGMENT

	Insurance Segment **Segment Identification (111-AM) = "Ø4"**			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE	Ø = Not Specified 1 = No Override 2 = Override 3 = Full Time Student 4 = Disabled Dependent 5 = Dependent Parent 6 = Significant Other	RW	*Imp Guide:* Required if needed for receiver inquiry validation and/or determination, when eligibility is not maintained at the dependent level. Required in special situations as defined by the code to clarify the eligibility of an individual, which may extend coverage. *Payer Requirement:* Required when needed in order to clarify member eligibility
3Ø1-C1	GROUP ID		RW	*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. Required if needed for pharmacy claim processing and payment. *Payer Requirement:* **REQUIRED for Part D.** Use value printed on card PLEASE NOTE: PART D Reversals ALSO require GROUP ID.
3Ø3-C3	PERSON CODE		RW	*Imp Guide:* Required if needed to uniquely identify the family members within the Cardholder ID. *Payer Requirement:* Use value printed on card to identify specific person when cardholder id is for family.
3Ø6-C6	PATIENT RELATIONSHIP CODE	Ø = Not specified 1 = Cardholder 2 = Spouse 3 = Child 4 = Other	R	*Imp Guide:* Required if needed to uniquely identify the relationship of the Patient to the Cardholder. *Payer Requirement:* Required to identify the relationship of patient to cardholder
997-G2	CMS PART D DEFINED QUALIFIED FACILITY	Y/N	RW	*Imp Guide:* Required if specified in trading partner agreement. *Payer Requirement:* Required to request Long Term Care Part D processing rules to be followed.

Patient Segment Questions	**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent	X	
This Segment is situational		Required to identify the patient

	Patient Segment **Segment Identification (111-AM) = "Ø1"**			**Claim Billing**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE		R	
31Ø-CA	PATIENT FIRST NAME		RW	*Imp Guide:* Required when the patient has a first name. *Payer Requirement:* Required to determine specific family members when twins, triplets, etc. apply
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		RW	*Imp Guide:* Optional.
323-CN	PATIENT CITY ADDRESS		RW	*Imp Guide:* Optional.
324-CO	PATIENT STATE / PROVINCE ADDRESS		RW	*Imp Guide:* Optional. Required on Mail Order claims for determination of Sales Tax requirements.
325-CP	PATIENT ZIP/POSTAL ZONE	Per NCPDP Data Dictionary comment: "This left-justified field contains the five-digit zip code, and may include the four-digit expanded zip code in which the patient is located. Examples: **If the zip code is 98765-4321, this field would reflect: 987654321.** If the zip code is 98765, this field would reflect: 98765 left justified."	RW	*Imp Guide:* Optional. When submitted value should only contain numeric characters. A dash is not allowed. • This applies to ALL zip code fields.
384-4X	PATIENT RESIDENCE	Ø - Not Specified 1 - Home 2 - Skilled Nursing Facility 3 - Nursing Facility 4 - Assisted Living Facility 5 - Custodial Care Facility 6 - Group Home 9 - Intermediate Care Facility/Individuals with Intellectual Disabilities 11 - Hospice 15 - Correctional Institution **The following codes will be ignored if submitted** 7 - Inpatient Psychiatric Facility 8 - Psychiatric Facility – Partial Hospitalization 1Ø - Residential Substance Abuse Treatment Facility 12 - Psychiatric Residential Treatment Facility 13 - Comprehensive Inpatient Rehabilitation Facility 14 - Homeless Shelter	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* Required when LTC processing edits and payment are desired Codes 2 and 5 are used for Medicare B wrap claims only and will be rejected in other instances. REQUIRED for all Part D claims
335-2C	PREGNANCY INDICATOR	Blank - Not Specified 1 - Not Pregnant 2 - Pregnant	RW	*Claim Billing/Encounter:* Required if pregnancy could result in different coverage, pricing, or patient financial responsibility.

	Patient Segment **Segment Identification (111-AM) = "Ø1"**			**Claim Billing**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Required if "required by law" as defined in the HIPAA final Privacy regulations section 164.5Ø1 definitions (45 CFR Parts 160 and 164 Standards for Privacy of Individually Identifiable Health Information; Final Rule - Thursday, December 28, 2000, page 82803 and following, and Wednesday, August 14, 2002, page 53267 and following.) *Payer Requirement:* When submitted, plan set up determines if submission will be used for different coverage, pricing or patient financial responsibility.

Claim Segment Questions	**Check**	**Claim Billing**
This Segment is always sent	X	MANDATORY SEGMENT
This payer does not support partial fills	X	

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing). For Vaccine Drug and Administration billing, value must be 1
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	Please see REVERSAL section for Rx Number requirements related to Reversals The Rx number submitted on the REVERSAL must be the same value as submitted on the CLAIM for matching to take place.
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = NDC	M	For Multi-ingredient compounds this should be ØØ
4Ø7-D7	PRODUCT/SERVICE ID		M	For Multi-ingredient compounds this should be Ø (1 zero) *Per NCPDP Implementation Guide:* *If billing for a multi-ingredient prescription, Product/Service ID (4Ø7-D7) is zero. (Zero means one "Ø".)*
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	NOTE: Fill Number is also required for a B2 Reversal
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	1 Not a Compound 2 Compound	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Values Ø - 9	R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED		RW	*Imp Guide:* Required if necessary for plan benefit administration. *Payer Requirement:* Informational use only.
419-DJ	PRESCRIPTION ORIGIN CODE	Ø - Not Known 1 - Written 2 - Telephone 3 - Electronic - *used when prescription obtained via SCRIPT or HL7 Standard transactions.*	RW	*Imp Guide:* Required if necessary for plan benefit administration. *Payer Requirement:* Required for all prescriptions regardless whether NEW or REFILL or the type of

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		4 - Facsimile 5 - Pharmacy –*used when a pharmacy generates a new Rx number from an existing Rx number.*		claim (Medicare Part D, Medicaid, Commercial, etc.). The value of zero will be rejected for a NEW Rx number for Part D claims and is likely to be rejected on refills and other claim types. Pharmacy generated new Rx numbers (store to store transfer within a chain, etc.) are expected to be identified with code 5.
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	*Imp Guide:* Required if Submission Clarification Code (42Ø-DK) is used. *Payer Requirement:* Same as Imp Guide
42Ø-DK	SUBMISSION CLARIFICATION CODE	1 - No Override 2 - Other Override 3 - Vacation Supply 4 – Lost/Damaged Prescription 5 - Therapy Change 6 - Starter Dose 7 - Medically Necessary 8 - Process Compound for Approved Ingredients 9 - Encounters 1Ø - Meets Plan Limitations 11 - Certification on File 12 - DME Replacement Indicator 13 - Payer-Recognized Emergency / Disaster Assistance Request 14 - Long Term Care Leave of Absence 15 - Long Term Care Replacement Medication 16 - Long Term Care Emergency box (kit) or automated dispensing machine 17 - Long Term Care Emergency supply remainder 18 - Long Term Care Patient Admit/Readmit Indicator 19 - Split Billing - Used only in long-term care settings. 2Ø - 34ØB 57- Discharge Medication See expanded table below for codes related to Prescriber Validation, Short Cycle Dispensing, and Shortened Days Supply. 99 - Other	RW	*Imp Guide:* Required if clarification is needed and value submitted is greater than zero (Ø). If the Date of Service (4Ø1-D1) contains the subsequent payer coverage date, the Submission Clarification Code (42Ø-DK) is required with value of "19" (Split Billing – indicates the quantity dispensed is the remainder billed to a subsequent payer when Medicare Part A expires. Used only in long-term care settings) for individual unit of use medications. *Payer Requirement:* Required to indicate the need for special handling to override normal processing. *Payer Requirement*: Value of '20' must be submitted when 340B drugs are dispensed to a Managed Medicaid and Fee-For-Service Medicaid members.
	42Ø-DK SUBMISSION CLARIFICATION CODES RELATED TO <u>PRESCRIBER/PHARMACY VALIDATION</u> 42 - Prescriber ID Submitted is valid and prescribing requirements have been validated. 43 - Prescriber's DEA is active with DEA Authorized Prescriptive Right. ~~44 – For prescriber ID submitted, associated prescriber DEA recently licensed or re-activated~~ **Code SUNSET as of April 2013** 45 - Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule 46 -Prescriber's DEA has prescriptive authority for this drug DEA Schedule • Codes 47 and 48 are noted below 49 - Prescriber does not currently have an active Type 1 NPI (code will be accepted per syntax but rejected as NOT SUPPORTED) 50 - Prescriber's active Medicare Fee For Service enrollment status has been validated 51 - Pharmacy's active Medicare Fee For Service enrollment status has been validated 52 - Prescriber's state license with prescriptive authority has been validated- Indicates the prescriber ID submitted is associated to a healthcare provider with the applicable state license that grants prescriptive authority. 55 - Prescriber Is Enrolled in State Medicaid Program has been validated. 56 - Pharmacy Is Enrolled in State Medicaid Program has been validated.			

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
	42Ø-DK SUBMISSION CLARIFICATION CODES RELATED TO <u>LTC SHORT CYCLE DISPENSING</u> 21 - LTC dispensing: 14 days or less not applicable - Fourteen day or less dispensing is not applicable due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e vacation supply, leave of absence, ebox, spitter dose). Medication quantities are dispensed as billed 22 - LTC dispensing: 7 days - Pharmacy dispenses medication in 7 day supplies 23 - LTC dispensing: 4 days - Pharmacy dispenses medication in 4 day supplies 24 - LTC dispensing: 3 days - Pharmacy dispenses medication in 3 day supplies 25 - LTC dispensing: 2 days - Pharmacy dispenses medication in 2 day supplies 26 - LTC dispensing: 1 day - Pharmacy or remote (multiple shifts) dispenses medication in 1 day supplies 27 - LTC dispensing: 4-3 days - Pharmacy dispenses medication in 4 day, then 3 day supplies 28 - LTC dispensing: 2-2-3 days - Pharmacy dispenses medication in 2 day, then 2 day, then 3 day supplies 29 - LTC dispensing: daily and 3-day weekend - Pharmacy or remote dispensed daily during the week and combines multiple days dispensing for weekends 3Ø - LTC dispensing: Per shift dispensing - Remote dispensing per shift (multiple med passes) 31 - LTC dispensing: Per med pass dispensing - Remote dispensing per med pass 32 - LTC dispensing: PRN on demand - Remote dispensing on demand as needed 33 - LTC dispensing: 7 day or less cycle not otherwise represented 34 - LTC dispensing: 14 days dispensing - Pharmacy dispenses medication in 14 day supplies 35 - LTC dispensing: 8-14 day dispensing method not listed above - 8-14-Day dispensing cycle not otherwise represented 36 - LTC dispensing: dispensed outside short cycle - Claim was originally submitted to a payer other than Medicare Part D and was subsequently determined to be Part D.			
	42Ø-DK SUBMISSION CLARIFICATION CODES RELATED TO <u>Shortened Days Supply for purposes of Trial or Synchronization fills</u> 47 - Shortened Days Supply Fill - only used to request an override to plan limitations when a shortened days supply is being dispensed. 48 - Fill Subsequent to a Shortened Days Supply Fill - only used to request an override to plan limitations when a fill subsequent to a shortened days supply is being dispensed.			
429-DT	SPECIAL PACKAGING INDICATOR	*See Codes listed below*	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* LTC claims for brand oral solid drugs must be submitted with the correct values to identify a claim as LTC and the correct Submission Clarification Codes and Special Packaging indicators.
	Ø -Not Specified 1 - Not Unit Dose - Indicates the product is not being dispensed in special unit dose packaging. 2 - Manufacturer Unit Dose - A code used to indicate a distinct dose as determined by the manufacturer. 3 - Pharmacy Unit Dose – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose. 4 - Pharmacy Unit Dose Patient Compliance Packaging – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5 - Pharmacy Multi-drug Patient Compliance Packaging - Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6 - Remote Device Unit Dose - Drug is dispensed at the facility, via a remote device, in a unit of use package. 7 - Remote Device Multi-drug Compliance - Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8 - Manufacturer Unit of Use Package (not unit dose) - Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).			
3Ø8-C8	OTHER COVERAGE CODE	Ø - Not Specified by patient 1 - No other coverage 2 - Other coverage exists-payment collected 3 - Other Coverage Billed – claim not covered 4 - Other coverage exists-payment not collected 8 - Claim is billing for patient financial responsibility only	RW	*Imp Guide:* Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers. Required for Coordination of Benefits. *Payer Requirement:* Required for non-primary claim submissions. **See Plan Profile sheet for COB requirements per PCN set up.** In the case of multiple prior payers, Other Coverage Code represents the final 'result' of all payers billed:

	Claim Segment Segment Identification (111-AM) = "Ø7"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				• If at least one prior payer returned a PAID response - use 2, 4 or 8 as noted in Plan Profile sheet • If ALL prior payers REJECTED - use 3.
6ØØ-28	UNIT OF MEASURE	EA - Each GM - ML - Milliliters	RW	*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* Informational use only.
454-EK	SCHEDULED PRESCRIPTION ID NUMBER	Prescription serial number must be either a Prescription Serial Number from a NYS Official Prescription or one of the current codes allowed by Medicaid: 1) Prescriptions on hospital or clinic prescription pads use HHHHHHHH; 2) Prescriptions written by out-of-State prescribers use ZZZZZZZZ; 3) Prescriptions submitted by fax or electronically use EEEEEEEE; 4) Oral prescriptions use 99999999; 5) For patient-specific orders for nursing home patients and children in foster care, use NNNNNNNN.	RW	*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* Required as of September 2012 for NYS (New York State) Medicaid Rx billing.
418-DI	LEVEL OF SERVICE	Ø - Not Specified 1 - Patient consultation 2 - Home delivery 3 - Emergency 4 - 24 hour service 5 - Patient consultation regarding generic product selection 6 - In-Home Service	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* Same as Imp Guide
461-EU	PRIOR AUTHORIZATION TYPE CODE	Ø - Not Specified 1 - Prior Authorization 2 - Medical Certification 3 - EPSDT (Early Periodic Screening Diagnosis Treatment) 4- Exemption from Copay and/or Coinsurance 5 - Exemption from RX 6 - Family Planning Indicator 7 - TANF (Temporary Assistance for Needy Families) 8 - Payer Defined Exemption 9 - Emergency Preparedness	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* Required to indicate the need for special handling Value of "4" required when LTC providers are requesting refunds for waived co-pays for eligible Low-Income Cost-Sharing Subsidy Level IV beneficiaries
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* Required to indicate the need for special handling to override a normal processing rejection.
995-E2	ROUTE OF ADMINISTRATION	SNOMED Code	RW	*Imp Guide:* Required if specified in trading partner agreement.

	Claim Segment Segment Identification (111-AM) = "Ø7"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: Required when needed by plan for proper adjudication. See Plan Profile Sheets.
996-G1	COMPOUND TYPE	Ø1 - Anti-infective Ø2 - Ionotropic Ø3 - Chemotherapy Ø4 - Pain management Ø5 - TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition Ø6 - Hydration Ø7 – Ophthalmic Ø8- Z0790 Ø9 – Z0791 10 – Z0792 11 – Z0793 99 - Other	RW	*Imp Guide:* Required if specified in trading partner agreement. *Payer Requirement:* Request pharmacies submit when billing for a compound. Informational use only.
147-U7	PHARMACY SERVICE TYPE	1 - Community/Retail Pharmacy Services. 2 - Compounding Pharmacy Services. 3 - Home Infusion Therapy Provider Services. 4 - Institutional Pharmacy Services. 5 - Long Term Care Pharmacy Services. 6 - Mail Order Pharmacy Services. 7 - Managed Care Organization Pharmacy Services. 8 - Specialty Care Pharmacy Services. 99 - Other	RW	*Imp Guide:* Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer. *Payer Requirement:* Required when pharmacy expects non-standard reimbursement calculation or special processing because of this value. Required for LTC determination. Mail Order and Specialty pharmacies are required to provide this for proper reimbursement. Required for ALL Part D claims

Pricing Segment Questions	**Check**	**Claim Billing**
This Segment is always sent	X	MANDATORY SEGMENT

	Pricing Segment Segment Identification (111-AM) = "11"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		RW	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement:* Same as Imp Guide
433-DX	PATIENT PAID AMOUNT SUBMITTED		**NOT USED** **If value other than zero is sent; claim will REJECT**	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* **This field is not used for COB billing. We have no clients who require patient out of pocket collection and reporting *prior to* adjudication therefore we assume a non-zero value submitted here to be an invalid COB submission and will REJECT.**
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement:* Same as Imp Guide Required when pharmacy is entitled to a Vaccine Administration Fee
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW	*Imp Guide:* Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.

				Payer Requirement: Same as Imp Guide
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	Ø1 - Delivery Cost Ø2 - Shipping Cost Ø3 - Postage Cost Ø4 - Administrative Cost Ø9 - Compound Preparation Cost 99 - Other	RW	*Imp Guide:* Required if Other Amount Claimed Submitted (48Ø-H9) is used. *Payer Requirement:* Same as Imp Guide
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement:* Same as Imp Guide
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		RW	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement:* Flat Sales Tax Amount should be submitted when a governing jurisdiction requires the collection of a fixed amount for all applicable prescriptions (Example: In the early 2000s Kentucky collected a 0.15 'flat' tax for Rxs). Pharmacy is responsible for submission of accurate flat tax values for use in payment calculation. Required when flat sales tax is applicable to product dispensed.
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		RW	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement:* Pharmacy is responsible for submission of accurate percentage tax values for use in payment calculation. Required when percentage sales tax is applicable to product dispensed. Tax Amounts that vary based on the rate and cost of the prescription must be submitted as Percentage Sales Tax Amount along with the applicable Percentage Tax Rate and Percentage Tax Basis. **NOTE: For payment of Percentage Tax, all 3 Percentage Tax fields must be submitted:** • PERCENTAGE SALES TAX AMOUNT SUBMITTED • PERCENTAGE SALES TAX RATE SUBMITTED • PERCENTAGE SALES TAX BASIS SUBMITTED
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	Format s9(3)v4 6.85% tax should be submitted as 6850{	RW	*Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX). *Payer Requirement:* Same as Imp Guide. Required when sales tax is applicable to product dispensed to provide the rate for use in payment calculation.
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	Blank - Not Specified Ø2 - Ingredient Cost Ø3 - Ingredient Cost + Dispensing Fee	RW	*Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).

				Payer Requirement: Same as Imp Guide. Required when sales tax is applicable to product dispensed to provide the basis for use in payment calculation
426-DQ	USUAL AND CUSTOMARY CHARGE		R	*Imp Guide:* Required if needed per trading partner agreement. *Payer Requirement:* Required on all claim submissions. In the case of a Vaccine where the product is also administered to the patient, U&C value should include the Administration fee so any comparison to Usual and Customary calculates correctly.
43Ø-DU	GROSS AMOUNT DUE		R	Must summarize according to NCPDP criteria. Ingredient Cost Submitted (4Ø9-D9) + Dispensing Fee Submitted (412-DC) + Flat Sales Tax Amt Submitted (481-HA) + Percent Sales Tax Amt Submitted' (482-GE) + Incentive Amount Submitted (438-E3) + Other Amount Claimed (48Ø-H9)
423-DN	BASIS OF COST DETERMINATION		RW	*Imp Guide:* Required if needed for receiver claim/encounter adjudication. *Payer Requirement:* For informational use only
	ØØ – Default Ø1 – AWP (Average Wholesale Price) Ø2 – Local Wholesaler Ø3 – Direct Ø4 – EAC (Estimated Acquisition Cost)- Ø5 – Acquisition Ø6 – MAC (Maximum Allowable Cost) Ø7 – Usual & Customary Ø8 – 34ØB /Disproportionate Share Pricing/Public Health Service Ø9 – Other 1Ø - ASP (Average Sales Price) 11 - AMP (Average Manufacturer Price) 12 - WAC (Wholesale Acquisition Cost) 13 - Special Patient Pricing 14 - Cost basis on un-reportable quantities			

Prescriber Segment Questions		**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent		X	
This Segment is situational			Required to identify the prescriber of the product billed
	Prescriber Segment Segment Identification (111-AM) = "Ø3"		**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = National Provider Identifier (NPI) Use of the following codes is discouraged, however will be accepted if prescriber NPI is not available: 12 – DEA Ø6 – UPIN Ø8 – State License	RW	*Imp Guide:* Required if Prescriber ID (411-DB) is used. *Payer Requirement:* Required to identify the prescriber of the product dispensed. For Part D as of Jan 1, 2013: • NPI of prescriber is required. • Rejections for Prescriber Ids that cannot be matched to our prescriber database may be overridden by use of Submission Clarification Codes which allows pharmacy to go 'at risk' for the submission of the claim.
411-DB	PRESCRIBER ID		RW	*Imp Guide:* Required if this field could result in different coverage or patient financial responsibility.

				Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* Required to identify the prescriber of the product dispensed. In a 'declared emergency situation' when the pharmacist prescribes, NPI of the pharmacy may be submitted
427-DR	PRESCRIBER LAST NAME		RW	*Imp Guide:* Required when the Prescriber ID (411-DB) is not known. Required if needed for Prescriber ID (411-DB) validation/clarification. *Payer Requirement:* Required to identify the prescriber of the product dispensed. May be used to validate NPI
498-PM	PRESCRIBER PHONE NUMBER			*Payer Requirement:* Informational use only.
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER			*Payer Requirement:* Informational use only.
421-DL	PRIMARY CARE PROVIDER ID			*Payer Requirement:* Informational use only.
47Ø-4E	PRIMARY CARE PROVIDER LAST NAME			*Payer Requirement:* Informational use only.
364-2J	PRESCRIBER FIRST NAME			*Payer Requirement:* Informational use only.
365-2K	PRESCRIBER STREET ADDRESS			*Payer Requirement:* Informational use only.
366-2M	PRESCRIBER CITY ADDRESS			*Payer Requirement:* Informational use only.
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS			*Payer Requirement:* Informational use only.
368-2P	PRESCRIBER ZIP/POSTAL ZONE			*Payer Requirement:* Informational use only. When submitted value should only contain numeric characters. A dash is not allowed. • This applies to ALL zip code fields.

Coordination of Benefits/Other Payments Segment Questions	**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc claims. Will reject if Segment sent on primary claim

MedImpact provides Plan Profile Sheets indicating specific Methods required for COB Billing. Rather than provide multiple separate payer sheets that are very repetitive, we have opted to indicate here the 2 common types of COB methods for billing.

- If Government COB is necessary, a separate Payer Sheet exists and should be requested.

The METHOD required for COB is noted on the PLAN PROFILE SHEET.

Scenario 1 - Other Payer Amount Paid Repetitions Only	X	
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions Only	X	
Scenario 3 - Other Payer Amount Paid and Other Payer-Patient Responsibility Amount, -(Government Programs)	See to right	Government COB is required by select clients. Use Payer Sheet named '**MedImpact D.0 Payer Sheet - Medicaid w/Government COB Processing"** for processing details
Benefit Stage Repetitions can be required by any supplemental plan that meets governmental regulations allowing them to receive these *regardless* of COB billing method.		The requirement for Benefit Stage submission will be noted on the PLAN PROFILE SHEET. Since these can be submitted regardless of COB method, the details for Benefit Stage submission are listed ONCE and follow the two common COB methods detailed here for populating the COB Segment.

Scenario 1 - Other Payer Amount Paid Repetitions Only – when payment response has been received
OCC 2/4 - Method Required for Part D COB when Other Payer has PAID on claim.

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing** Scenario 1 - Other Payer Amount Paid Repetitions Only
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	Number of payers submitted in the COB segment.
338-5C	OTHER PAYER COVERAGE TYPE	Blank - Not Specified Ø1 - Primary Ø2 - Secondary Ø3 - Tertiary Ø4 - Quaternary Ø5 - Quinary Ø6 - Senary Ø7 - Septenary Ø8 - Octonary Ø9 - Nonary	M	Submit as necessary
339-6C	OTHER PAYER ID QUALIFIER	Ø3 - Bin Number See note below if Other Payer was billed off line	R	*Imp Guide:* Required if Other Payer ID (34Ø-7C) is used. *Payer Requirement:* Submit Ø3 for BIN number
34Ø-7C	OTHER PAYER ID	If no BIN exists due to billing of a non-online payer, please use value 999999 as the BIN of the Other Payer.	R	*Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication. *Payer Requirement:* Required to indicate what other coverage was billed.
443-E8	OTHER PAYER DATE		R	*Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. *Payer Requirement:* Required
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	*Imp Guide:* Required if Other Payer Amount Paid Qualifier (342-HC) is used. *Payer Requirement:* Required for COB billing methods when this prior payer has PAID claim with Total Amount Paid value > or equal to zero and per Plan Profile Sheet COB billing is based on Other Payer Amount Paid values.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø1 Delivery Ø2 Shipping Ø3 Postage Ø4 Administrative Ø5 Incentive Ø7 Drug Benefit Ø9 Compound Preparation Cost 1Ø Sales Tax	RW	*Imp Guide:* Required if Other Payer Amount Paid (431-DV) is used. *Payer Requirement:* Same as Imp Guide Required for COB billing method when this prior payer has PAID claim with a receivable value to pharmacy and per Plan Profile Sheet billing is based on Other Payer Amount Paid.
431-DV	OTHER PAYER AMOUNT PAID	Required even if value is zero	RW	*Imp Guide:* Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. *Payer Requirement:* Required for COB billing methods when this prior payer has PAID claim. Negative values ARE accepted with OCC 4 and treated as zero.

Scenario 1 - Other Payer Amount Paid Repetitions Only – when prior payer has rejected
OCC 3 - Reject Count and Code will be submitted instead of the **Other Payer Amount Paid** criteria.

471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	*Imp Guide:* Required if Other Payer Reject Code (472-6E) is used. *Payer Requirement:* Required when this prior payer has REJECTED the claim.
472-6E	OTHER PAYER REJECT CODE	NCPDP Reject Codes only	RW	*Imp Guide:* Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered). *Payer Requirement:* Required when this prior payer has REJECTED the claim to indicate the reason for the rejection.

NOTE: Benefit Stage Repetitions in the COB Segment apply to plans that FOLLOW a Medicare Part D payment. Per standard, these might be required for any COB method so for that reason the field requirements are noted ONCE below. WHEN necessary for a COB submission, this requirement will be noted on PLAN PROFLIE SHEET.

Scenario 2- Other Payer-Patient Responsibility Amount Repetitions Only - when payment response has been received

OCC 8

Not Used for Part D COB

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing** Scenario 2- Other Payer-Patient Responsibility Amount Repetitions Only
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	Number of payers submitted in the COB segment.
338-5C	OTHER PAYER COVERAGE TYPE	Blank- Not Specified Ø1 - Primary Ø2 - Secondary Ø3 - Tertiary Ø4 - Quaternary Ø5 - Quinary Ø6 - Senary Ø7 - Septenary Ø8 - Octonary Ø9 - Nonary	M	Submit as necessary
339-6C	OTHER PAYER ID QUALIFIER	Ø3 - Bin Number See note below if Other Payer was billed off line	R	*Imp Guide:* Required if Other Payer ID (34Ø-7C) is used. *Payer Requirement:* Submit Ø3 for BIN number.
34Ø-7C	OTHER PAYER ID	If no BIN exists due to billing of a non-online payer, please use value 999999 as the BIN.	R	*Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication. *Payer Requirement:* Required to indicate what other coverage was billed.
443-E8	OTHER PAYER DATE		R	*Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. *Payer Requirement:* Required
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing** Scenario 2- Other Payer-Patient Responsibility Amount Repetitions Only
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: Required for COB billing methods when this prior payer has PAID the claim with the patient having some payment responsibility and per Plan Profile Sheet COB billing is based on Patient Responsibility amounts (formerly Copay Only)
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Blank- Not Specified Ø1 - Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Ø2 - Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 - Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 - Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5 - Amount of Copay (518-FI) as reported by previous payer. Ø6 - Patient Pay Amount (5Ø5-F5) as reported by previous payer. Ø7 - Amount of Coinsurance (572-4U) as reported by previous payer. Ø8 - Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer Ø9 - Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer 1Ø - Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. 11 - Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer. 12 - Amount Attributed to Coverage Gap (137-UP) that was collected from the patient due to a coverage gap as reported by previous payer. 13 - Amount Attributed to Processor Fee (571-NZ) as reported by previous payer	RW	*Imp Guide:* Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. *Payer Requirement:* Same as Imp Guide. **We expect components parts of Patient Pay Amount by prior Payers to be submitted** If the Patient Pay Amount does not balance to the component parts we are allowing submission of Ø6 – Patient Pay Amount as reported by previous payers, however we feel submission of this value should be minimal from any pharmacy. Qualifier Ø6 usage will be monitored and auditable as components of Patient Pay Amount is the preferable submission for this COB method. Qualifier values related to Product Choice by patient will result in a DENIAL if the submitted OPPRA sum exceeds contact rate for claim. Submission of qualifier Ø6 with a value exceeding contract rate will result in payment at contract rate. When qualifier Ø6 is submitted it should only be submitted with the Other Payer-Patient Responsibility Amount Count of 1.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	*Imp Guide:* Required if necessary for patient financial responsibility only billing. Required if necessary for state/federal/regulatory agency programs. Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted. *Payer Requirement:* Required for COB billing methods when this prior payer has PAID claim and patient has payment responsibility

Scenario 2- Other Payer-Patient Responsibility Amount Repetitions Only - when prior payer has rejected

OCC 3 - Reject Count and Code will be submitted instead of the **Other Payer-Patient Responsibility Amount** criteria.

471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	*Imp Guide:* Required if Other Payer Reject Code (472-6E) is used. *Payer Requirement:* Required when this prior payer has REJECTED the claim.
472-6E	OTHER PAYER REJECT CODE	NCPDP Reject Codes only	RW	*Imp Guide:* Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered). *Payer Requirement:* Required when this prior payer has REJECTED the claim to indicate the reason for the rejection.

NOTE: Benefit Stage Repetitions may be required for any COB method. Field requirements are noted ONCE below.

Benefit Stage Repetitions may be attached when applicable to COB Segment for any method of COB submission. Plan Profile sheet will detail whether Benefit Stage data is required or not for COB processing.

392-MU	BENEFIT STAGE COUNT	Maximum count of 4.		*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used. *Payer Requirement:* Required when Medicare Part D claim was paid and COB payer meets regulatory requirements. Regulation will be noted PLAN PROFILE SHEET
393-MV	BENEFIT STAGE QUALIFIER	Ø1 - Deductible Ø2 - Initial Benefit Ø3 - Coverage Gap (donut hole) Ø4 - Catastrophic Coverage 5Ø - Not paid under Part D, paid under Part C benefit (for MA-PD plan) 51 - Not paid under Part D, paid under Part C benefit (for MA-PD plan) – Beneficiary is a Qualified Medicare Beneficiary – pharmacy should not attempt to collect cost-share, but instead should attempt to bill COB to Medicaid Coverage 61 – Part D drug not paid by Part D plan benefit, paid as or under a co-administered insured benefit only 62 - Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only 63 - Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid under Medicaid benefit only of the Medicare/Medicaid (MMP) plan. 7Ø - Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing 8Ø - Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing 90 - Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered		*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used. *Payer Requirement:* Same as Imp Guide NOTE: Acceptance of Code 6Ø was discontinued per standard as of Jan 1, 2013.

		by the Part D plan		
394-MW	BENEFIT STAGE AMOUNT			*Imp Guide:* Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* Required when Medicare Part D claim was paid and COB payer meets regulatory requirements. Regulation will be noted PLAN PROFILE SHEET

DUR/PPS Segment Questions	**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when DUR is returned on Rejection and pharmacy wishes to submit reason DUR rejection should be overridden.

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	*Imp Guide:* Required if DUR/PPS Segment is used. *Payer Requirement:* Required when needed by plan for proper adjudication When multiple DUR alerts have been returned for pharmacy review, the expectation is that pharmacy will review all and respond using the most critical alert to indicate the highest level of professional service completed.
439-E4	REASON FOR SERVICE CODE		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* Required when needed by plan for proper adjudication.
44Ø-E5	PROFESSIONAL SERVICE CODE		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* Required when needed by plan for proper adjudication. For Part D Vaccine Administration, value of "MA" required.
441-E6	RESULT OF SERVICE CODE		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service.

				Payer Requirement: Required when needed by plan for proper adjudication.
474-8E	DUR/PPS LEVEL OF EFFORT	Ø Not Specified 11 Level 1 (Lowest) 12 Level 2 13 Level 3 14 Level 4 15 Level 5 (Highest) 16 Low Level 17 Mid-Level 18 Mid-Level 19 High Level 20 High Level 21 High Level 22 High Level	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement*: Required when needed by plan for proper adjudication. See Plan Profile Sheets.
475-J9	DUR CO-AGENT ID QUALIFIER	Valid codes accepted however ignored.	S	*Imp Guide:* Required if DUR Co-Agent ID (476-H6) is used. *Payer Requirement:* Informational use only.
476-H6	DUR CO-AGENT ID		S	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* Informational use only.

Compound Segment Questions	**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when claim is for a Compounded Rx

	Compound Segment Segment Identification (111-AM) = "1Ø"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	See NCPDP Data Dictionary for applicable Code values	M	Required if segment is used.
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	1 = Each 2 = Grams 3 = Milliliters	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3 - NDC	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		RW	*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement:* Required if segment is used.
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	*See Code list below*	RW	*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement:* Required if segment is used.
	ØØ – Default Ø1 – AWP (Average Wholesale Price) Ø2 – Local Wholesaler Ø3 – Direct Ø4 – EAC (Estimated Acquisition Cost)- Ø5 – Acquisition Ø6 – MAC (Maximum Allowable Cost) Ø7 – Usual & Customary Ø8 – 34ØB /Disproportionate Share Pricing/Public Health Service Ø9 – Other			

	1Ø - ASP (Average Sales Price) 11 - AMP (Average Manufacturer Price) 12 - WAC (Wholesale Acquisition Cost) 13 - Special Patient Pricing 14 - Cost basis on un-reportable quantities

Clinical Segment Questions	**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when Diagnosis code is necessary for Claim adjudication

	Clinical Segment **Segment Identification (111-AM) = "13"**			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	*Imp Guide:* Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. *Payer Requirement:* Same as Imp Guide
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1 = ICD-9 Ø2 = ICD-1Ø	RW	*Imp Guide:* Required if Diagnosis Code (424-DO) is used. *Payer Requirement:* Same as Imp Guide
424-DO	DIAGNOSIS CODE	**PER HIPAA STANDARD, DECIMAL POINT SHOULD NOT BE INCLUDED IN ICD-1Ø DIAGNOSIS CODE VALUES.** For ICD-1Ø, decimal is always between position 3 and 4 so per standard is implied similar to how decimal in dollar fields is implied and therefore NOT PRESENT.	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* Informational use only.

Segments that are NOT USED in B1 CLAIM BILLING TRANSACTION:

Pharmacy Provider Segment
Workers' Compensation Segment
Coupon Segment
Additional Documentation Segment
Facility Segment
Narrative Segment
Prior Authorization Segment

1.4.2 EMERGENCY PREPAREDNESS:

In the event of a 'declared emergency', the following guidelines will be followed:

Patient Segment

This *optional* segment is for the demographic information from which the patient has been displaced. This may/may not be where the patient is residing during the emergency.

322-CM	Patient Street Address	The street address of patient's home from where they were displaced.
323-CN	Patient City Address	The city of patient's home from where they were displaced.
324-CO	Patient State/Province Address	The state of patient's home from where they were displaced.
325-CP	Patient Zip/Postal Zone	The zip/postal code of patient's home from where they were displaced.

Claim Segment

Submission Clarification Code (420-DK):

13	Payer-Recognized Emergency/ Disaster Assistance Request	The pharmacist is indicating that an override is needed based on an emergency/disaster situation recognized by the payer.

Prescriber Segment

411-DB	Prescriber Id	In a 'declared emergency situation' when the pharmacist prescribes, the organizational (type 2) NPI of the pharmacy may be submitted. Note: In this case, only a Prescriber Id Qualifier (field 466-EZ) of 01 is valid.

1.4.3 VACCINE BILLING REQUIREMENTS

The procedure for **Vaccine Billing** has not changed with the conversion from 5.1 to D.0.

When pharamcies are contracted for this service the billing must occur using the NCPDP recommended method. Most of the claim information is the same as a 'normal' claim billing. The specifics for Vaccine billing include the following:

Claim Segment: Mandatory

Field #	*NCPDP field name*	*Value*
111-AM	SEGMENT IDENTIFICATION	07
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	For Vaccine Drug and Administration billing, value must be 1
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Rx number for the Vaccine and Administration
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = NDC
4Ø7-D7	PRODUCT/SERVICE ID	NDC of the Vaccine product
	Other Claim Segment Fields as required	

Pricing segment: Mandatory

Field #	*NCPDP field name*	*Value*
111-AM	SEGMENT IDENTIFICATION	11
4Ø9-D9	INGREDIENT COST SUBMITTED	Ingredient cost of product
412-DC	DISPENSING FEE SUBMITTED	
438-E3	INCENTIVE AMOUNT SUBMITTED	Must be greater than zero or claim will deny. This should be the contracted Administration Fee. If not contracted for Vaccine payment this will be ignored.
43Ø-DU	GROSS AMOUNT DUE	This must be the sum of Ingredient Cost Submitted (4Ø9-D9), Dispensing Fee Submitted (412-DC), Flat Sales Tax Amount Submitted (481-HA) Percentage Sales Tax Amount Submitted (482-GE), Incentive Amount Submitted (438-E3) Other Amount Claimed (48Ø-H9)
426-DQ	USUAL AND CUSTOMARY CHARGE	U&C must include the Vaccine Administration Fee so lesser than logic works properly.

DUR/PPS Segment: Required

Field #	*NCPDP field name*	*Value*
111-AM	SEGMENT IDENTIFICATION	08
473-7E	DUR/PPS CODE COUNTER	Must equal 1.

44Ø-E5	PROFESSIONAL SERVICE CODE	Must be MA - Medication Administered If this is NOT present the Administrative fee will be ignored.

**** End of Request Claim Billing (B1) Payer Sheet Template****

**** Start of Response Claim Billing/Claim (B1) Payer Sheet Template****

1.5 RESPONSE TO CLAIM BILLING

1.5.1 CLAIM BILLING ACCEPTED/PAID (OR DUPLICATE OF PAID) RESPONSE

GENERAL INFORMATION

Payer Name: MedImpact Healthcare Systems	Date: June 10, 2019	
Plan Name/Group Name: Various	**BIN:** See Bins listed on page 2	**PCN**: As specified on Plan Profile Sheets and/or ID cards

The following lists the segments and fields in a Claim Billing response (Paid or Duplicate of Paid) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

MedImpact recommends providers code their systems to receive ALL valid response data associated with a B1 Accepted/Paid or Duplicate of Paid response. Population of situational response fields is dependent on payment rules, governmental messaging requirements, as well as client and pharmacy agreement.

Response Transaction Header Segment Questions	**Check**	**Claim Billing Accepted/Paid (or Duplicate of Paid)**
This Segment is always sent	X	MANDATORY SEGMENT

	Response Transaction Header Segment			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Header Segment Questions	**Check**	**Claim Billing Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Provided when needed to include information on an accepted claim transmission that may be of value to pharmacy or patient.

	Response Message Segment Segment Identification (111-AM) = "2Ø"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		RW	*Imp Guide:* Required if text is needed for clarification or detail. *Payer Requirement:* When claim(s) are PAID, transmission related messaging may be sent for pharmacy review.

Response Insurance Header Segment Questions	**Check**	**Claim Billing Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Provided when needed to indicate member coverage or reimbursement criteria.

	Response Insurance Segment Segment Identification (111-AM) = "25"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø1-C1	GROUP ID		RW	*Imp Guide:* Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available. Required to identify the actual group that was used when multiple group coverages exist. *Payer Requirement:* Same as Imp Guide
524-FO	PLAN ID		RW	*Imp Guide:* Required if needed to identify the actual plan parameters, benefit, or coverage criteria, when available. Required to identify the actual plan ID that was used when multiple group coverages exist. Required if needed to contain the actual plan ID if unknown to the receiver. *Payer Requirement:* Same as Imp Guide

Response Patient Segment Questions	**Check**	**Claim Billing Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Returned when Patient has been verified as being enrolled in benefit.

	Response Patient Segment Segment Identification (111-AM) = "29"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
31Ø-CA	PATIENT FIRST NAME		RW	*Imp Guide:* Required if known. *Payer Requirement:* Returned when enrollment file match occurs to indicate the First Name on file for the Member id
311-CB	PATIENT LAST NAME		RW	*Imp Guide:* Required if known. *Payer Requirement: :* Returned when enrollment file match occurs to indicate the Last Name on file for the Member id

Response Status Segment Questions	Check	Claim Billing Accepted/Paid (or Duplicate of Paid)
This Segment is always sent	X	MANDATORY SEGMENT

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing Accepted/Paid (or Duplicate of Paid)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement* MedImpact unique Clam Id for transmitted claim. **When calling Help Desk, this id is the fastest means to identify the claim.**
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.	RW	*Imp Guide:* Required if Approved Message Code (548-6F) is used. *Payer Requirement:* Same as Imp Guide
548-6F	APPROVED MESSAGE CODE	*See list below*	RW	*Imp Guide:* Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. *Payer Requirement:* Used for Transition of Care messaging for Part D.
	Blank - Not Specified ØØ1 - Generic Available ØØ2 - Non-Formulary Drug ØØ3 - Maintenance Drug ØØ4 –Dispense/Dispensed/Dispensing Supply During Transition Benefit ØØ5 - Dispense/Dispensed/Dispensing Supply During Transition Benefit/Prior Authorization Required ØØ6 - Dispense/Dispensed/Dispensing Supply During Transition Benefit/Non-Formulary ØØ7 - Dispense/Dispensed/Dispensing Supply During Transition Benefit/Other Rejection ØØ8 - Emergency Supply Situation ØØ9 - Emergency Dispense Situation/Prior Authorization Required Ø1Ø - Emergency Supply Situation/Non-Formulary Ø11 - Emergency Supply Situation/Other Rejection Ø12 - Level of Care Change Ø13 - Level Of Care Change/ Prior Authorization Required Ø14 - Level Of Care Change /Non-Formulary Ø15 - Level Of Care Change /Other Rejection Ø16 - PMP Reportable Required Ø17 - PMP Reporting Completed Ø18 - Provide Notice: Medicare Prescription Drug Coverage and Your Rights Ø44 – Plan's Prescriber data base determined prescriptive authority criteria not met, flagged for retrospective review Ø45 - Prescriber active enrollment with Medicaid Fee For Service/MCO required. Flagged for retrospective review. Ø46 - Pharmacy active enrollment with Medicaid Fee For Service/MCO required. Flagged for retrospective review. **For Medicare Part D Prescriber Validation and Override** Ø19 - The Submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review Ø2Ø - For the Submitted Prescriber ID, the Associated DEA Number is Not Found – Flagged for Retrospective Review Ø21 - For the Submitted Prescriber ID, the associated DEA Number is Inactive or Expired – Flagged for Retrospective Review Ø22 - For the submitted Prescriber ID, the associated DEA Number does not allow this drug DEA Schedule – Flagged for Retrospective Review Ø23 - Prorated copayment applied based on days supply. Plan has prorated the copayment based on days supply. Ø24 - The submitted Prescriber ID is Not Found - Flagged for Retrospective Review Ø25 - The submitted Prescriber ID is associated to a Deceased Prescriber – Flagged for Retrospective Review Ø26 - Prescriber Type 1 NPI Required - Flagged for Retrospective Review Ø27 - The submitted Prescriber DEA does not allow this drug DEA Schedule – Flagged for Retrospective Review Ø28 - Type 1 NPI Required, Claim Paid Based on Plan's Prescriber NPI Data - When the plan pays and chooses to send a cross walked NPI on the PDE Ø29 - Grace period claim. Patient required to pay for the full cost of the prescription. Patient to contact plan.			

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
	Ø3Ø - Prescriber active enrollment with Medicare Fee For Service required. Flagged for retrospective review- Value returned only if Submission Clarification Code 5Ø was submitted and accepted Ø31 - Pharmacy active enrollment with Medicare Fee For Service required. Flagged for retrospective review- Value returned only if Submission Clarification Code 51 was submitted and accepted Ø32 - Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted Ø33 - Hospice Compassionate First Dispense – Hospice provides compassionate first dispense for a drug not yet identified if covered by part D			
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* Same as Imp Guide
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 - Ø9 for the number of lines of messaging.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* Same as Imp Guide
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail. *Payer Requirement:* Same as Imp Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:* Same as Imp Guide
987-MA	URL		RW	*Imp Guide:* Provided for informational purposes only to relay health care communications via the Internet. *Payer Requirement:* Future Use

Response Claim Segment Questions	**Check**	**Claim Billing Accepted/Paid (or Duplicate of Paid)**
This Segment is always sent	X	MANDATORY SEGMENT

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response Pricing Segment Questions	**Check**	**Claim Billing Accepted/Paid (or Duplicate of Paid)**
This Segment is always sent	X	MANDATORY SEGMENT

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø5-F5	PATIENT PAY AMOUNT		R	
5Ø6-F6	INGREDIENT COST PAID		R	

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø7-F7	DISPENSING FEE PAID		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. *Payer Requirement:* Same as Imp Guide
557-AV	TAX EXEMPT INDICATOR	Blank - Not Specified 1 Payer/Plan is Tax Exempt 3 Patient is Tax Exempt 4 Payer/Plan and Patient are Tax Exempt	RW	*Imp Guide:* Required if the sender (health plan) and/or patient is tax exempt and exemption applies to this billing. *Payer Requirement:* Same as Imp Guide
558-AW	FLAT SALES TAX AMOUNT PAID		RW	*Imp Guide:* Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (Ø) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement. *Payer Requirement:* Same as Imp Guide
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. Required if Percentage Sales Tax Amount Submitted (482-GE) is greater than zero (Ø). Required if Percentage Sales Tax Rate Paid (56Ø-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used. *Payer Requirement:* Same as Imp Guide
56Ø-AY	PERCENTAGE SALES TAX RATE PAID		RW	*Imp Guide:* Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø). *Payer Requirement:* Same as Imp Guide
561-AZ	PERCENTAGE SALES TAX BASIS PAID		RW	*Imp Guide:* Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø). *Payer Requirement:* Same as Imp Guide
521-FL	INCENTIVE AMOUNT PAID		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø). *Payer Requirement:* Same as Imp Guide
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	RW	*Imp Guide:* Required if Other Amount Paid (565-J4) is used. *Payer Requirement:* Returned when values related to the following reimbursements are returned.
564-J3	OTHER AMOUNT PAID QUALIFIER	Ø1 - Delivery Ø2 - Shipping Ø3 - Postage Ø4 - Administrative Ø9 - Compound Preparation Cost 99 - Other	RW	*Imp Guide:* Required if Other Amount Paid (565-J4) is used. *Payer Requirement:* Values provided per trading partner agreements.
565-J4	OTHER AMOUNT PAID		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. Required if Other Amount Claimed Submitted (48Ø-H9) is greater than zero (Ø). *Payer Requirement:* Same as Imp Guide

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported. *Payer Requirement:* Returned on COB payment response when OPAP dollars used to reduce primary claim payment.
5Ø9-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	See Code list below	RW	*Imp Guide:* Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing *Payer Requirement:* Same as Imp Guide
	Ø - Not Specified 1 - Ingredient Cost Paid as Submitted 2 - Ingredient Cost Reduced to AWP Pricing 3 - Ingredient Cost Reduced to AWP Less X% Pricing 4 - Usual & Customary Paid as Submitted 5 - Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary 6 - MAC Pricing Ingredient Cost Paid 7 - MAC Pricing Ingredient Cost Reduced to MAC 8 - Contract Pricing 9 - Acquisition Pricing 1Ø - ASP (Average Sales Price) 11 - AMP (Average Manufacturer Price) 12 - 34ØB/Disproportionate Share/Public Health Service Pricing 13 - WAC (Wholesale Acquisition Cost) 14 - Other Payer-Patient Responsibility Amount 15 - Patient Pay Amount 16 - Coupon Payment – Indicates reimbursement was based on the coupon amount determined by the processor 17 - Special Patient Reimbursement *18* - Direct Price (DP) 19 - State Fee Schedule (SFS) Reimbursement 2Ø - National Average Drug Acquisition Cost (NADAC) 21 - State Average Acquisition Cost (AAC) 23 - Indicates the reimbursement was based on the contracted or state fee schedule rate for the Original Manufacturer Product ID for the repackaged drug. 24 – Federal Upper Limit (FUL)			
COMPONENTS OF PATIENT PAY AMOUNT				
523-FN	AMOUNT ATTRIBUTED TO SALES TAX		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes sales tax that is the financial responsibility of the member but is not also included in any of the other fields that add up to Patient Pay Amount. *Payer Requirement:* Same as Imp Guide
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes deductible *Payer Requirement:* Same as Imp Guide
518-FI	AMOUNT OF COPAY		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes copay as patient financial responsibility. *Payer Requirement:* Same as Imp Guide

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
52Ø-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes amount exceeding periodic benefit maximum. *Payer Requirement:* Same as Imp Guide
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE		RW	*Imp Guide:* Required if the customer is responsible for 1ØØ% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay. *Payer Requirement:* Same as Imp Guide
572-4U	AMOUNT OF COINSURANCE		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes coinsurance as patient financial responsibility. *Payer Requirement:* Same as Imp Guide
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT		RW	*Imp Guide:* Required when the patient meets the plan-funded assistance criteria, to reduce Patient Pay Amount (5Ø5-F5). The resulting Patient Pay Amount (5Ø5-F5) must be greater than or equal to zero. *Payer Requirement:* Same as Imp Guide. Future Use
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another *Payer Requirement:* Same as Imp Guide
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand drug. *Payer Requirement:* Same as Imp Guide
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a non-preferred formulary product. *Payer Requirement:* Same as Imp Guide
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand non-preferred formulary product. *Payer Requirement:* Same as Imp Guide
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP		RW	*Imp Guide:* Required when the patient's financial responsibility is due to the coverage gap. *Payer Requirement:* Same as Imp Guide
BENEFIT STAGE FIELDS				
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	RW	*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used. *Payer Requirement:* Returned on Part D paid claim response.

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
393-MV	BENEFIT STAGE QUALIFIER	Ø1 - Deductible Ø2 - Initial Benefit Ø3 - Coverage Gap (donut hole) Ø4 - Catastrophic Coverage 5Ø - Not paid under Part D, paid under Part C benefit (for MA-PD plan) 51 - Not paid under Part D, paid under Part C benefit (for MA-PD plan) – Beneficiary is a Qualified Medicare Beneficiary – pharmacy should not attempt to collect cost-share, but instead should attempt to bill COB to Medicaid Coverage 61 – Part D drug not paid by Part D plan benefit, paid as or under a co-administered insured benefit only 62 - Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only 63 - Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid under Medicaid benefit only of the Medicare/Medicaid (MMP) plan. 7Ø - Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing 8Ø - Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing 90 - Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan	RW	*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used. *Payer Requirement:* Returned on Part D paid claim response. *Note: Codes 61 and 62 replaced the use of 6Ø as of January 1, 2013*
394-MW	BENEFIT STAGE AMOUNT		RW	*Imp Guide:* Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* Returned on Part D paid claim response. Also returned with applicable qualifier value when claim billed to a Part D bin is paid *outside* of the Part D benefit. Values returned reflect where claim paid in member's benefit.
INFORMATIONAL FIELDS				
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT		RW	*Imp Guide:* Provided for informational purposes only. *Payer Requirement:* When applicable, the amount that has accumulated toward the deductible.

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
513-FD	REMAINING DEDUCTIBLE AMOUNT		RW	*Imp Guide:* Provided for informational purposes only. *Payer Requirement:* When applicable, the amount of deductible that remains to be met.
514-FE	REMAINING BENEFIT AMOUNT		RW	*Imp Guide:* Provided for informational purposes only. *Payer Requirement:* When applicable, the amount of benefit that has not yet been used.
575-EQ	PATIENT SALES TAX AMOUNT			*Imp Guide:* Used when necessary to identify the Patient's portion of the Sales Tax. *Payer Requirement:* Same as Imp Guide
574-2Y	PLAN SALES TAX AMOUNT			*Imp Guide:* Used when necessary to identify the Plan's portion of the Sales Tax. *Payer Requirement:* Same as Imp Guide
148-U8	INGREDIENT COST CONTRACTED/REIMBURSABLE AMOUNT			*Imp Guide:* Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency. *Payer Requirement:* Returned when payment is based on Patient Responsibility COB or Patient Pay Amount.
149-U9	DISPENSING FEE CONTRACTED/REIMBURSABLE AMOUNT			*Imp Guide:* Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency. *Payer Requirement:* Returned when payment is based on Patient Responsibility COB or Patient Pay Amount
577-G3	ESTIMATED GENERIC SAVINGS			*Imp Guide:* This information should be provided when a patient selected the brand drug and a generic form of the drug was available. It will contain an estimate of the difference between the cost of the brand drug and the generic drug, when the brand drug is more expensive than the generic. *Payer Requirement:* Same as Imp Guide
128-UC	SPENDING ACCOUNT AMOUNT REMAINING			*Imp Guide:* This dollar amount will be provided, if known, to the receiver when the transaction had spending account dollars reported as part of the patient pay amount. *Payer Requirement:* Same as Imp Guide

PARTIAL FILLS are not supported at this time, therefore Partial Fill RESPONSE FIELDS are not listed.

Response DUR/PPS Segment Questions	**Check**	**Claim Billing Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when needed to supply additional information for a utilization conflict or as required by plan.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing– Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	*Imp Guide:* Required if Reason For Service Code (439-E4) is used. *Payer Requirement:* Same as Imp Guide
439-E4	REASON FOR SERVICE CODE	See NCPDP Data Dictionary for codes	RW	*Imp Guide:* Required if utilization conflict is detected. *Payer Requirement:* Same as Imp Guide.
528-FS	CLINICAL SIGNIFICANCE CODE	Blank = Not Specified 1 = Major 2 = Moderate 3 = Minor	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide.
529-FT	OTHER PHARMACY INDICATOR	∅ = Not specified 1 = Your pharmacy 2 - Other Pharmacy in Same Chain 3 = Other pharmacy	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide
53Ø-FU	PREVIOUS DATE OF FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. *Payer Requirement:* Same as Imp Guide.
531-FV	QUANTITY OF PREVIOUS FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used. *Payer Requirement:* Same as Imp Guide.
532-FW	DATABASE INDICATOR	1 = First Databank	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide.
533-FX	OTHER PRESCRIBER INDICATOR	∅ = Not Specified 2 - Other Prescriber 1 = Same Prescriber	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide.
544-FY	DUR FREE TEXT MESSAGE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide.
57Ø-NS	DUR ADDITIONAL TEXT		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide.

Response Coordination of Benefits/Other Payers Segment Questions	**Check**	**Claim Billing** **Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Will be provided on a PAID claim when OTHER HEALTH INFORMATION exists for Member to assist in reducing their out of pocket cost.

	Response Coordination of Benefits/Other Payers Segment **Segment Identification (111-AM) = "28"**			**Claim Billing** **Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER	Ø3 – Bin Number	RW	*Imp Guide:* Required if Other Payer ID (34Ø-7C) is used. *Payer Requirement:* When sponsor provides coverage information that is to follow their processing, that information will be supplied to the pharmacy on the Paid claim response.
34Ø-7C	OTHER PAYER ID		RW	*Imp Guide:* Required if other insurance information is available for coordination of benefits. *Payer Requirement:* CMS data will be by Bin Number
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	*Imp Guide:* Required if other insurance information is available for coordination of benefits. *Payer Requirement:* When supplied by sponsor.
356-NU	OTHER PAYER CARDHOLDER ID		RW	*Imp Guide:* Required if other insurance information is available for coordination of benefits. *Payer Requirement:* When supplied by sponsor.
992-MJ	OTHER PAYER GROUP ID		RW	*Imp Guide:* Required if other insurance information is available for coordination of benefits. *Payer Requirement:* When supplied by sponsor.
142-UV	OTHER PAYER PERSON CODE		RW	*Imp Guide:* Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer. *Payer Requirement:* When supplied by sponsor.
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	*Imp Guide:* Required if needed to provide a support telephone number of the other payer to the receiver. *Payer Requirement:* When supplied by sponsor.
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	*Imp Guide:* Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer. *Payer Requirement:* When supplied by sponsor.
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		RW	*Imp Guide:* Required when other coverage is known which is after the Date of Service submitted. *Payer Requirement:* When supplied by sponsor.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		RW	*Imp Guide:* Required when other coverage is known which is after the Date of Service submitted. *Payer Requirement:* When supplied by sponsor.

Segments that are NOT USED in B1 CLAIM BILLING - ACCEPTED/PAID OR DUPLICATE OF PAID RESPONSE

Response Insurance Additional Information Segment
Response Prior Authorization Segment

1.5.2 CLAIM BILLING ACCEPTED/REJECTED RESPONSE

MedImpact recommends providers code their systems to receive ALL valid response data associated with a B1 Accepted/Rejected response. Population of situational response fields is dependent on processing rules, governmental messaging requirements, as well as client and pharmacy agreement.

CLAIM BILLING ACCEPTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Billing Accepted/Rejected
This Segment is always sent	X	MANDATORY SEGMENT

	Response Transaction Header Segment			Claim Billing Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Provided when needed to include information on an accepted claim transmission that may be of value to pharmacy or patient.

	Response Message Segment Segment Identification (111-AM) = "2Ø"			Claim Billing Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		RW	*Imp Guide:* Required if text is needed for clarification or detail. *Payer Requirement:* When claim(s) are REJECTED, transmission related messaging may be sent for pharmacy review.

Response Insurance Segment Questions	Check	Claim Billing Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Provided when needed to indicate member coverage criteria.

	Response Insurance Segment Segment Identification (111-AM) = "25"			Claim Billing Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø1-C1	GROUP ID		RW	*Imp Guide:* Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available. Required to identify the actual group that was used when multiple group coverages exist. *Payer Requirement:* Same as Imp Guide
524-FO	PLAN ID		RW	*Imp Guide:* Required if needed to identify the actual plan parameters, benefit, or coverage criteria, when available.

	Response Insurance Segment Segment Identification (111-AM) = "25"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Required to identify the actual plan ID that was used when multiple group coverages exist. Required if needed to contain the actual plan ID if unknown to the receiver. *Payer Requirement:* Same as Imp Guide

Response Patient Segment Questions	**Check**	**Claim Billing Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Returned when Patient has been verified as being enrolled in benefit. If rejection reason is because patient was NOT able to be identified, segment will not be returned.

	Response Patient Segment Segment Identification (111-AM) = "29"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
31Ø-CA	PATIENT FIRST NAME		RW	*Imp Guide:* Required if known. *Payer Requirement:* Returned when enrollment file match occurs to indicate the First Name on file for the Member id
311-CB	PATIENT LAST NAME		RW	*Imp Guide:* Required if known. *Payer Requirement: :* Returned when enrollment file match occurs to indicate the Last Name on file for the Member id

Response Status Segment Questions	**Check**	**Claim Billing Accepted/Rejected**
This Segment is always sent	X	MANDATORY SEGMENT

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement* MedImpact unique Clam Id for transmitted claim. **When calling Help Desk, this id is the fastest means to identify the claim.**
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence. *Payer Requirement:* Same as Imp Guide MedImpact will be using the **Reject Occurrence Indicator (546-4F)** to indicate repeating field rejections. • In the case of COMPOUNDS this will be used to indicate an ingredient level rejection. Example: Reject Code 70 with the Occurrence indicator of 3 will indicate that the Product submitted as the **third** ingredient is Not Covered/Plan Benefit Exclusion. • In the case of COB, this will direct the provider to the PAYER LOOP in error.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* Same as Imp Guide
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 - Ø9 for the number of lines of messaging. 1Ø – Next Refill Date (format CCYYMMDD)	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* Same as Imp Guide
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail. *Payer Requirement:* Same as Imp Guide.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:* Same as Imp Guide
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement:* Same as Imp Guide
55Ø-8F	HELP DESK PHONE NUMBER		RW	*Imp Guide:* Required if needed to provide a support telephone number to the receiver. *Payer Requirement:* Same as Imp Guide
987-MA	URL			*Imp Guide:* Provided for informational purposes only to relay health care communications via the Internet. *Payer Requirement:* Future Use

Response Claim Segment Questions	**Check**	**Claim Billing Accepted/Rejected**
This Segment is always sent	X	MANDATORY SEGMENT

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	**Check**	**Claim Billing Accepted/Rejected**
This Segment is always sent		
This Segment is situational	X	Required when needed to supply additional information for a utilization conflict or as required by plan.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	*Imp Guide:* Required if Reason For Service Code (439-E4) is used. *Payer Requirement:* Same as Imp Guide
439-E4	REASON FOR SERVICE CODE	See NCPDP Data Dictionary for codes	RW	*Imp Guide:* Required if utilization conflict is detected. *Payer Requirement:* Same as Imp Guide
528-FS	CLINICAL SIGNIFICANCE CODE	Blank = Not Specified 1 = Major 2 = Moderate 3 = Minor	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide
529-FT	OTHER PHARMACY INDICATOR	Ø Not Specified 1 - Your Pharmacy 2 - Other Pharmacy in Same Chain 3 - Other Pharmacy	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide
53Ø-FU	PREVIOUS DATE OF FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. *Payer Requirement:* Same as Imp Guide
531-FV	QUANTITY OF PREVIOUS FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used. *Payer Requirement:* Same as Imp Guide
532-FW	DATABASE INDICATOR	1 = First Databank	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide
533-FX	OTHER PRESCRIBER INDICATOR	0 - Not Specified 1 - Same Prescriber 2 - Other Prescriber	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide
544-FY	DUR FREE TEXT MESSAGE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing Accepted/Rejected**
57Ø-NS	DUR ADDITIONAL TEXT		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide

Response Coordination of Benefits/Other Payers Segment Questions	**Check**	**Claim Billing/ Accepted/Rejected**
This Segment is always sent		
This Segment is situational	X	Will be provided on a REJECTED claim when OTHER HEALTH INFORMATION exists for Member.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER	Ø3 – Bin Number	RW	*Imp Guide:* Required if Other Payer ID (34Ø-7C) is used. *Payer Requirement:* When Medicare Part D sponsor provides coverage information of payers that precede their processing, that information will be supplied to the pharmacy on the Rejected claim response should the claim be billed to Part D as primary
34Ø-7C	OTHER PAYER ID		RW	*Imp Guide:* Required if other insurance information is available for coordination of benefits. *Payer Requirement:* CMS data will be by Bin Number
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	*Imp Guide:* Required if other insurance information is available for coordination of benefits. *Payer Requirement:* When supplied by sponsor.
356-NU	OTHER PAYER CARDHOLDER ID		RW	*Imp Guide:* Required if other insurance information is available for coordination of benefits. *Payer Requirement:* When supplied by sponsor.
992-MJ	OTHER PAYER GROUP ID		RW	*Imp Guide:* Required if other insurance information is available for coordination of benefits. *Payer Requirement:* When supplied by sponsor.
142-UV	OTHER PAYER PERSON CODE		RW	*Imp Guide:* Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer. *Payer Requirement:* When supplied by sponsor.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	*Imp Guide:* Required if needed to provide a support telephone number of the other payer to the receiver. *Payer Requirement:* When supplied by sponsor.
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	*Imp Guide:* Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer. *Payer Requirement:* When supplied by sponsor.
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		RW	*Imp Guide:* Required when other coverage is known which is after the Date of Service submitted. *Payer Requirement:* When supplied by sponsor.
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		RW	*Imp Guide:* Required when other coverage is known which is after the Date of Service submitted. *Payer Requirement:* When supplied by sponsor.

Segment that is NOT SUPPORTED in B1 CLAIM BILLING ACCEPTED/REJECTED RESPONSE

Response Prior Authorization Segment

Segments that are NOT USED in B1 CLAIM BILLING ACCEPTED/REJECTED RESPONSE

Response Insurance Additional Information Segment
Response Pricing Segment

1.5.3 CLAIM BILLING REJECTED/REJECTED RESPONSE

MedImpact recommends providers code their systems to receive ALL valid response data associated with a B1 Rejected/Rejected response. Population of situational response fields is dependent on processing rules, governmental messaging requirements, as well as client and pharmacy agreement.

CLAIM BILLING REJECTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Billing Rejected/Rejected
This Segment is always sent	X	MANDATORY SEGMENT

	Response Transaction Header Segment			Claim Billing Rejected/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Messaging provided to assist pharmacies in resolution of a Rejected *Transmission*

	Response Message Segment Segment Identification (111-AM) = "2Ø"			Claim Billing Rejected/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		RW	*Imp Guide:* Required if text is needed for clarification or detail. *Payer Requirement:* When claim transmission is REJECTED, contains text information to further explain the reason for the rejection of the transmission.

Response Status Segment Questions	Check	Claim Billing Rejected/Rejected
This Segment is always sent	X	MANDATORY SEGMENT

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing Rejected/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement* MedImpact unique Clam Id for transmitted claim. **When calling Help Desk, this id is the fastest means to identify the claim.**
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	If rejection reason can be determined
511-FB	REJECT CODE		R	If rejection reason can be determined for use with applicable Reject Code

546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence. *Payer Requirement:* Same as Imp Guide
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* When supplied, count will equal the number of sets associated with UH,FQ and UG fields
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 - Ø9 for the number of lines of messaging.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* Same as Imp Guide
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail. *Payer Requirement:* Same as Imp Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:* Same as Imp Guide

Segments that are NOT USED in B1 CLAIM BILLING REJECTED/REJECTED RESPONSE

Response Insurance Segment
Response Insurance Additional Information Segment
Response Patient Segment
Response Insurance Segment
Response Claim Segment
Response Pricing Segment
Response DUR/PPS Segment
Response Prior Authorization Segment
Response Coordination of Benefits/Other Payers Segment

**** End of Response Claim Billing (B1) Payer Sheet Template****

2. NCPDP VERSION D CLAIM REVERSAL

2.1 REQUEST CLAIM REVERSAL PAYER SHEET

**** Start of Request Claim Reversal (B2) Payer Sheet Template****

GENERAL INFORMATION

Payer Name: MedImpact Healthcare Systems	Date: June 10, 2019	
Plan Name/Group Name: Various	**BIN:** See Bins listed on page 2	**PCN:** As specified on Plan Profile Sheets and/or ID cards

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?) Specify timeframe	90 days

CLAIM REVERSAL TRANSACTION

2.1.1 GENERAL REVERSAL NOTES:

2.1.1.1 REVERSALS RX NUMBER

Reversals must be submitted with the SAME Rx number as was submitted on the Original Paid Claim.

2.1.1.2 REVERSALS COB

Reversals of COB claims should be performed in the correct "back out order" meaning LAST claim billed must be Reversed First until getting to the Primary Claim or a Claim to be re-submitted.

- If a claim has been billed as Primary, Secondary, Tertiary and the pharmacy wishes to re-process the Secondary claim, the Tertiary Claim must be reversed first, then the Secondary reversal. At this point the pharmacy may re-process the Secondary claim and as required, the Tertiary claim as well/
- The reversal of a COB claim must contain the COB Segment with Other Payer Coverage Type so in the case MedImpact is the payer of more than one claim for the Pharmacy, Rx, Date of Service and Fill number, the claim for reversal can be identified correctly.

The following lists the segments and fields in a Claim Reversal Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Transaction Header Segment Questions	Check	Claim Reversal
This Segment is always sent	X	MANDATORY SEGMENT
Source of certification ID's required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Claim Reversal
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	See Bins listed on page 2	M	

	Transaction Header Segment			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	As specified on Plan Profile Sheets and/or ID cards	M	Should be same value as submitted on B1 claim
1Ø9-A9	TRANSACTION COUNT	1 through 4 supported.	M	Multiple reversals in a Transmission must be for same patient and same Date of Service for each transaction to be reversed. Claim Submission for Medicare Part D is one transaction per transmission so reversal is the same.
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 - NPI	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blanks	M	

Insurance Segment Questions	**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required to assist in identifying the clam to reverse.

	Insurance Segment Segment Identification (111-AM) = "Ø4"			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	
3Ø1-C1	GROUP ID		RW Reqd for Part D Reversal matching	*Imp Guide:* Required if needed to match the reversal to the original billing transaction. *Payer Requirement:* Value submitted on claim should be included on reversal.

Claim Segment Questions	**Check**	**Claim Reversal**
This Segment is always sent	X	MANDATORY SEGMENT

	Claim Segment Segment Identification (111-AM) = "Ø7"			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B2", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	Same value as submitted on claim
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = NDC	M	Same value as submitted on claim
4Ø7-D7	PRODUCT/SERVICE ID		M	Same value as submitted on claim
4Ø3-D3	FILL NUMBER		RW	*Imp Guide:* Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (4Ø2-D2) occur on the same day. *Payer Requirement:* **REQUIRED.** Same value as submitted on claim. Used as 'tie break' if multiple fills of same Rx/DOS allowed
3Ø8-C8	OTHER COVERAGE CODE		RW	*Imp Guide:* Required if needed by receiver to match the claim that is being reversed.

				Payer Requirement: Required when reversing a COB Claim. Same value as submitted on claim Used as 'tie break' if multiple fills of same Rx/DOS allowed
147-U7	PHARMACY SERVICE TYPE	1 - Community/Retail Pharmacy Services. 2 - Compounding Pharmacy Services. 3 - Home Infusion Therapy Provider Services. 4 - Institutional Pharmacy Services. 5 - Long Term Care Pharmacy Services. 6 - Mail Order Pharmacy Services. 7 - Managed Care Organization Pharmacy Services. 8 - Specialty Care Pharmacy Services. 99 - Other	RW	*Imp Guide:* Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer. *Payer Requirement:* Same value as submitted on claim

Coordination of Benefits/Other Payments Segment Questions	**Check**	**Claim Reversal**
This Segment is always sent		
This Segment is situational	X	Should be sent when original claim was COB. Identifies specific claim to be reversed in the case where processor has paid two or more of the claims.

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	Used to identify the specific claim when we have processed multiple iterations of the claims (example: Primary and Secondary, Primary and Tertiary, Secondary and Quaternary, etc)

Segments that are NOT SUPPORTED in B2 Reversal

Pricing Segment
DUR/PPS Segment

Segments that are NOT USED in B2 Reversal

Patient Segment
Pharmacy Provider Segment
Prescriber Segment
Workers' Compensation Segment
Coupon Segment
Compound Segment
Prior Authorization Segment
Clinical Segment
Additional Documentation Segment
Facility Segment
Narrative Segment

**** End of Request Claim Reversal (B2) Payer Sheet Template****

2.2 CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

**** Start of Claim Reversal Response (B2) Payer Sheet Template****

GENERAL INFORMATION

Payer Name: MedImpact Healthcare Systems	Date: June 10, 2019	
Plan Name/Group Name: Various	**BIN:** See Bins listed on page 2	**PCN**: As specified on Plan Profile Sheets and/or ID cards

CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

The following lists the segments and fields in a Claim Reversal response (Approved) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

MedImpact recommends providers code their systems to receive ALL valid response data associated with a B2 Accepted/Approved response. Population of situational response fields is dependent on payment rules, governmental messaging requirements, as well as client and pharmacy agreement.

Response Transaction Header Segment Questions	**Check**	**Claim Reversal – Accepted/Approved**
This Segment is always sent	X	MANDATORY SEGMENT

	Response Transaction Header Segment			**Claim Reversal – Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Header Segment Questions	**Check**	**Claim Reversal – Accepted/Approved**
This Segment is always sent		
This Segment is situational	X	Provided when needed to include information on an accepted reversal transmission that may be of value to pharmacy or patient.

	Response Message Segment Segment Identification (111-AM) = "2Ø"			**Claim Reversal – Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		RW	*Imp Guide:* Required if text is needed for clarification or detail. *Payer Requirement:* When reversal(s) are successful, transmission related messaging may be sent to pharmacy for review.

Response Status Segment Questions	**Check**	**Claim Reversal – Accepted/Approved**
This Segment is always sent	X	MANDATORY SEGMENT

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Reversal – Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	

5Ø3-F3	AUTHORIZATION NUMBER		RW	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement* MedImpact unique Clam Id for transmitted claim. **When calling Help Desk, this id is the fastest means to identify the claim.**
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* Same as Imp Guide
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 - Ø9 for the number of lines of messaging.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* Same as Imp Guide
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail. *Payer Requirement:* Same as Imp Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:* Same as Imp Guide

Response Claim Segment Questions		**Check**		**Claim Reversal – Accepted/Approved**
This Segment is always sent		X		MANDATORY SEGMENT
	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Reversal – Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Segment that is NOT SUPPORTED in B2 Reversal Accepted/Approved Response

Response Pricing Segment

Segments that are NOT USED in B2 Reversal Accepted/Approved Response

Response Insurance Segment
Response Insurance Additional Information Segment
Response Patient Segment
Response DUR/PPS Segment
Response Prior Authorization Segment
Response Coordination of Benefits/Other Payers Segment

2.3 CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

MedImpact recommends providers code their systems to receive ALL valid response data associated with a B2 Accepted/Rejected response. Population of situational response fields is dependent on payment rules, governmental messaging requirements, as well as client and pharmacy agreement.

CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Reversal - Accepted/Rejected
This Segment is always sent	X	MANDATORY SEGMENT

	Response Transaction Header Segment			Claim Reversal – Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions		Check	Claim Reversal - Accepted/Rejected
This Segment is always sent			
This Segment is situational		X	Provided when needed to include information on a Rejected reversal transmission that may be of value to pharmacy or patient.
	Response Message Segment Segment Identification (111-AM) = "2Ø"		**Claim Reversal – Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		RW	*Imp Guide:* Required if text is needed for clarification or detail. *Payer Requirement:* Same as Imp Guide

Response Status Segment Questions		Check	Claim Reversal - Accepted/Rejected
This Segment is always sent		X	MANDATORY SEGMENT
	Response Status Segment Segment Identification (111-AM) = "21"		**Claim Reversal – Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement* MedImpact unique Clam Id for transmitted claim. **When calling Help Desk, this id is the fastest means to identify the claim.**
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence. *Payer Requirement:* Same as Imp Guide

13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* Same as Imp Guide
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 - Ø9 for the number of lines of messaging.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* Same as Imp Guide
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail. *Payer Requirement:* Same as Imp Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:* Same as Imp Guide

Response Claim Segment Questions		**Check**	**Claim Reversal - Accepted/Rejected**	
This Segment is always sent		X	MANDATORY SEGMENT	
	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Reversal – Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Segments that are NOT SUPPORTED in B2 Reversal Response – Accepted/Rejected

Pricing Segment
DUR/PPS Segment
Response Patient Segment
Response Insurance Segment

Segments that are NOT USED in B2 Reversal Response – Accepted/Rejected

Response Insurance Segment
Response Insurance Additional Information Segment
Response Patient Segment
Response Insurance Segment

2.4 CLAIM REVERSAL REJECTED/REJECTED RESPONSE

MedImpact recommends providers code their systems to receive ALL valid response data associated with a B2 Rejected /Rejected response. Population of situational response fields is dependent on payment rules, governmental messaging requirements, as well as client and pharmacy agreement.

CLAIM REVERSAL REJECTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Reversal - Rejected/Rejected
This Segment is always sent	X	MANDATORY SEGMENT

	Response Transaction Header Segment			Claim Reversal – Rejected/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Reversal – Rejected/Rejected
This Segment is always sent		
This Segment is situational	X	Messaging provided to assist pharmacies in resolution of a Rejected *Transmission*

	Response Message Segment Segment Identification (111-AM) = "2Ø"			Claim Reversal – Rejected/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		RW	*Imp Guide:* Required if text is needed for clarification or detail. *Payer Requirement:* When claim transmission is REJECTED, contains text information to further explain the reason for the rejection of the transmission.

Response Status Segment Questions	Check	Claim Reversal - Rejected/Rejected
This Segment is always sent	X	MANDATORY SEGMENT

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Rejected/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement* MedImpact unique Clam Id for transmitted claim. **When calling Help Desk, this id is the fastest means to identify the claim.**
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	

546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence. *Payer Requirement:* Same as Imp Guide
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* Same as Imp Guide
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 - Ø9 for the number of lines of messaging.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:* Same as Imp Guide
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail. *Payer Requirement:* Same as Imp Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:* Same as Imp Guide

Segments that are NOT USED in B1 CLAIM BILLING REJECTED/REJECTED RESPONSE

Response Insurance Segment
Response Insurance Additional Information Segment
Response Patient Segment
Response Claim Segment
Response Pricing Segment
Response DUR/PPS Segment
Response Prior Authorization Segment
Response Coordination of Benefits/Other Payers Segment

**** End of Claim Reversal (B2) Response Payer Sheet Template****