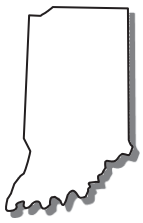
OptumRx Pharmacy Unit



INDIANA PRESCRIPTION DRUG PROGRAM

Companion Guide: NCPDP Version D.0 Transaction Payer Sheet

Companion Guide - NCPDP Version D.0 Transaction Payer Sheet

Address any comments concerning the contents of this manual to:

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Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	5/1/2013	N/A	New document	Pharmacy/Publications
Version 2.0	6/10/2013	1-11	Updated Compound Segment section	Pharmacy/Publications
Version 3.0	01/15/2015	1-3	Updated Patient Residence section	Pharmacy/Publications
Version 4.0	09/28/2015	1-5, 1-10	Updated Pricing Segment and DUR/PPS Segment sections	Pharmacy/Publications
Version 5.0	05/15/2017	1-11	Updated Result of Service Code list	Pharmacy/Publications
Version 6.0	06/01/2018		Updated Submission Clarification Code list, added Basis of Cost Determination and added 340B note to Ingredient Cost Submitted	Pharmacy/Publications
Version 7.0	07/01/2020	1-5	Added Use of Quantity Prescribed (46Ø-ET) field	Pharmacy/Publications
Version 8.0	12/15/2020	1-4, 1-5, 1-7, 1-10	Updated Claim Segment, Pricing Segment, and Prescriber Segment sections	Pharmacy/Publications

Table of Contents

Section 1: NCPDP Version D.Ø Claim Billing/Claim Rebill

Request Claim Billing/Claim Rebill Payer Sheet

**** Start of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet****

General Information

Payer Name: Indiana Medicaid	Date: May 24, 2013
BIN: 001553	PCN: INM
Processor: OptumRx	
Effective as of: May 24, 2013	NCPDP Telecommunication Standard Version/Release #: D.Ø.
NCPDP Data Dictionary Version Date: June 2Ø1Ø	NCPDP External Code List Version Date: June 2Ø1Ø

Other Transactions Supported

Transaction Code	Transaction Name
B2	REVERSAL

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

Note: *Fields that are not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the payer sheet.*

Claim Billing/Claim Rebill Transaction

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

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	ØØ1553	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	INM	M	
1Ø9-A9	TRANSACTION COUNT	1 = One occurrence 2 = Two occurrences 3 = Three occurrences 4 = Four occurrences Maximum of one allowed for compound transactions	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider Identifier (NPI)	M	
2Ø1-B1	SERVICE PROVIDER ID	1Ø digit NPI	M	
4Ø1-D1	DATE OF SERVICE	Format=CCYYMMDD	M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	ID assigned by the switch or processor to identify the software source. 1Ø character alphanumeric	M	

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

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID	12 digit numeric Indiana Medicaid member ID number	M	

Patient Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	X	

	Patient Segment **Segment Identification (111-AM) = "Ø1"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø4-C4	DATE OF BIRTH	Format=CCYYMMDD	R	
3Ø5-C5	PATIENT GENDER CODE	Ø = Not specified/Unknown 1 = Male 2 = Female	R	
31Ø-CA	PATIENT FIRST NAME	12 character alphanumeric	R	
311-CB	PATIENT LAST NAME	15 character alphanumeric	R	
335-2C	PREGNANCY INDICATOR	2 = Pregnant Utilized to remove copay for pregnancy related pharmacy claims.	RW	Use to notify payer that patient is pregnant to allow for omission of co-pay requirement.
384-4X	PATIENT RESIDENCE	1 = Home 2 = Skilled Nursing Facility. 3 = Nursing Facility 4 = Assisted Living Facility 5 = Custodial Care Facility 6 = Group Home 7 = Inpatient Psychiatric Facility 9 = Intermediate Care Facility/Mentally Retarded 11 = Hospice 12 = Psychiatric Residential Treatment Facility 13 = Comprehensive Inpatient Rehabilitation Facility Patient Residence is used to bypass copay if the member's level of care is not on file.	M	Use to indicate if a patient's residence is a long-term care facility, as defined by Centers for Medicare/Medicaid Services (CMS). Final Part D regulations from CMS (page 129) note: "We have expanded the definition of the term [3]long-term care facility[2] in §423.1ØØ of our final rule to encompass not only skilled nursing facilities, as defined in section 1819(a) of the Act, but also any medical institution or nursing facility for which payment is made for institutionalized individuals under Medicaid, as defined in section 19Ø2(q) (1) (B) of the Act.... Such an expansion would include ICFs/MR and inpatient psychiatric hospitals along with skilled nursing and nursing facilities in the definition of a long-term care facility, provided those facilities meet the requirements of a medical institution that receives Medicaid payments for institutionalized individuals under section19Ø2 (q)(1)(B) of the Act."

Claim Segment Questions	**Check**	**Claim Billing/Claim Rebill** **If Situational, *Payer Situation***
This Segment is always sent	X	
This payer **does not** support partial fills	X	

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided 12 digit numeric	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	ØØ = Compound	M	

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		Ø3 = National Drug Code (NDC)		
4Ø7-D7	PRODUCT/SERVICE ID	NDC (Drug Code) 11 characters	M	
442-E7	QUANTITY DISPENSED	Quantity dispensed expressed in metric decimal units Format=9999999.999	R	
4Ø3-D3	FILL NUMBER	ØØ = Original dispensing Ø1–99 = Refill number	R	
4Ø5-D5	DAYS SUPPLY	Estimated number of days the prescription will last. 3 digit numeric	R	
4Ø6-D6	COMPOUND CODE	1 = Not a compound 2 = Compound	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Code indicating whether the prescriber's instructions regarding generic substitution were followed. Ø = No Product Selection Indicated 1 = Substitution Not Allowed by Prescriber 2 = Substitution Allowed-Patient Requested Product Dispensed 3 = Substitution Allowed-Pharmacist Selected Product Dispensed 4 = Substitution Allowed-Generic Drug Not in Stock 5 = Substitution Allowed-Brand Drug Dispensed as a Generic 8 = Substitution Allowed-Generic Drug Not Available in Marketplace 9 = Substitution Allowed By Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product To Be Dispensed	R	Use to indicate prescriber's instructions regarding generic substitution
414-DE	DATE PRESCRIPTION WRITTEN	Format=CCYYMMDD	R	
415-DF	NUMBER OF REFILLS AUTHORIZED	00 =No refills authorized 01 - 99, with 99 as unlimited refills	R	
419-DJ	PRESCRIPTION ORIGIN CODE	0=Not known 1=Written 2=Telephone 3=Electronic 4=Facsimile 5=Pharmacy	R	Declared Emergency Situations: Required, submit the value of 5 – Pharmacy, for emergency RX refills as authorized by state declared emergency protocol
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3	RW	Required if Submission Clarification Code (42Ø-DK) is used

42Ø-DK	SUBMISSION CLARIFICATION CODE	Ø2 = Other Override Ø6 = Starter Dose Ø8 = Process compound for approved ingredients 2Ø = 340B Claim 42 = Prescriber ID Validated	RW	Required if clarification is needed and value submitted is greater than zero (Ø). Ø8 = Used to indicate that the provider agrees to be reimbursed for only the approved products within a compound 2Ø = Used if the product on the claim was dispensed from 340B stock *Declared Emergency Situations: Specific values required as follows:* Ø2 = 'Used when authorized by the payer in business cases not currently addressed by other SCC values,' to indicate the first of two-dose COVID-19 vaccine is being administered Ø6 = 'Used when indicating that the previous medication was a starter dose and now additional medication is needed to continue treatment,' to indicate the final dose of a two-dose COVID-19 vaccine is being administered. 42 = Prescriber ID Submitted is valid and prescribing requirements have been validated, used to request an override to prescriptive authority rules for emergency Rx refills where the pharmacist Type 1 NPI or pharmacy Type 2 NPI is submitted as the prescriber ID
46Ø -ET	QUANTITY PRESCRIBED		RW	Required when the transmission is for a Schedule II drug as defined in 21 CFR 1308.12 and per CMS-0055-F (Compliance Date 9/21/2020. Refer to the Version D.0 Editorial Document).
3Ø8-C8	OTHER COVERAGE CODE	Ø = Not Specified by patient 1 = No other coverage - Code used in coordination of benefits transactions to convey that no other coverage is available. 2 = Other coverage exists-payment	RW	Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers. Required if member has other insurance. Medicaid is payer of last resort.

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received. 3 = Other Coverage Billed – claim not covered - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment denied because the service is not covered. 4 = Other coverage exists-payment not collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received.		
418-DI	LEVEL OF SERVICE	ØØ = Not specified Ø3 = Emergency	RW	Required if this field could result in different coverage, pricing, or patient financial responsibility. Must be submitted with a maximum of 4 day supply to provide emergency override
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Prior authorization number	RW	Required when known

Pricing Segment Questions	**Check**	**Claim Billing/Claim Rebill** **If Situational, *Payer Situation***
This Segment is always sent	X	

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	INGREDIENT COST SUBMITTED	Submitted product component cost of the dispensed prescription. Format=s$$$$$$cc	R	This amount is included in the 'Gross Amount Due' (43Ø-DU). 340B claims – submit 340B cost here with the Basis of Cost Determination (423-DN) indicator of 'Ø8' Free product or no associated cost – submit cost here with the Basis of Cost Determination (423-DN) indicator of '15'
412-DC	DISPENSING FEE SUBMITTED	Dispensing fee submitted by the pharmacy. Format=s$$$$$$cc	RW	Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
438-E3	INCENTIVE AMOUNT SUBMITTED	Amount represents a fee that is submitted by the pharmacy for contractually agreed upon services. Format=s$$$$$$cc	RW	Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. The Incentive Amount is the administration fee, which is incorporated into the Submitted Usual and Customary Charge (426-DQ). The amount submitted in the Incentive Amount Submitted (438-E3) field will not be considered for reimbursement.
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW	Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	Ø1 = Delivery Cost Ø2 = Shipping Cost Ø3 = Postage Cost Ø4 = Administrative Cost Ø9 = Compound Preparation Cost Submitted 99 = Other - Different from those implied or specified	RW	Required if Other Amount Claimed Submitted (48Ø-H9) is used. Indiana Health Coverage Programs does not reimburse providers for any of the services billed in the OTHER AMOUNT CLAIMED SUBMITTED field
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED	Amount representing the additional incurred costs for a dispensed prescription or service. Format=s$$$$$$cc	RW	Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. Indiana Health Coverage Programs does not reimburse providers for any of the services billed in the OTHER AMOUNT CLAIMED SUBMITTED field.
481-HA	FLAT SALES TAX AMOUNT SUBMITTED	Format=s$$$$$$c	RW	Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. Indiana Health Coverage Programs does not reimburse providers for any sales tax on drugs dispensed by a registered pharmacist or licensed practitioner
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED	Format=s$$$$$$cc	RW	Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. Indiana Health Coverage Programs does not reimburse providers for any sales tax on drugs dispensed by a registered pharmacist or licensed practitioner
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	Format=s999.9999	RW	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). Indiana Health Coverage Programs does not reimburse providers for any sales tax on drugs dispensed by a registered pharmacist or licensed practitioner
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	Ø2 = Ingredient Cost Ø3 = Ingredient Cost + Dispensing Fee	RW	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).

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Indiana Health Coverage Programs does not reimburse providers for any sales tax on drugs dispensed by a registered pharmacist or licensed practitioner
426-DQ	USUAL AND CUSTOMARY CHARGE	Format=s$$$$$$cc	R	Required if needed per trading partner agreement. Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.
43Ø-DU	GROSS AMOUNT DUE	Total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (4Ø9-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (48Ø-H9). Format=s$$$$$$cc	R	
423-DN	BASIS OF COST DETERMINATION	ØØ = Default Ø1 = AWP Ø2 = Local wholesaler Ø3 = Direct Ø4 = EAC Ø5 = Acquisition Ø6 = MAC 6X = Brand medically necessary Ø7 = Usual and customary Ø8 = 340B/Disproportionate Share Pricing/Public Health Service Ø9 = Other 15 = Free product / no cost		Required for all claims.

Prescriber Segment Questions	**Check**	**Claim Billing/Claim Rebill** **If Situational, *Payer Situation***
This Segment is always sent	X	

	Prescriber Segment **Segment Identification (111-AM) = "Ø3"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = National Prescriber Identifier (NPI)	R	Required if Prescriber ID (411-DB) is used.

411-DB	PRESCRIBER ID	1Ø digit NPI	R	Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. *Declared Emergency Situations:* If no prescription or protocol is available, may use NPI for Dr. Kris Box per IDOH vaccine standing order. Pharmacist Type 1 NPI or Pharmacy Type 2 NPI may be submitted as allowed under state emergency Rx refill protocol for COVID-19 vaccine (needs to be used in conjunction with 42Ø-DK = '42').

Coordination of Benefits/Other Payments Segment Questions	**Check**	**Claim Billing/Claim Rebill If Situational, *Payer Situation***
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	X	

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill** **Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Count of other payment occurrences. Maximum count of 9	M	
338-5C	OTHER PAYER COVERAGE TYPE	Blank = Not Specified Ø1 = Primary – First Ø2 = Secondary – Second Ø3 = Tertiary – Third Ø4 = Quaternary – Fourth Ø5 = Quinary – Fifth Ø6 = Senary – Sixth Ø7 = Septenary - Seventh Ø8 = Octonary – Eighth Ø9 = Nonary – Ninth	M	
443-E8	OTHER PAYER DATE	Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits. Format=CCYYMMDD	RW	Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Count of the payer amount paid occurrences. Maximum count of 9	RW	Required if Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø1 = Delivery Ø2 = Shipping Ø3 = Postage Ø4 = Administrative Ø5 = Incentive Ø6 = Cognitive Service Ø7 = Drug Benefit Ø9 = Compound Preparation Cost 1Ø = Sales Tax	RW	Required if Other Payer Amount Paid (431-DV) is used.
431-DV	OTHER PAYER AMOUNT PAID	Amount of any payment known by the pharmacy from other sources. Format=s$$$$$$cc	RW	Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Required if Total Amount Paid (5Ø9-F9) from Other Payer is greater than zero (Ø).
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5	RW	Required if Other Payer Reject Code (472-6E) is used.
472-6E	OTHER PAYER REJECT CODE	The error encountered by the previous "Other Payer" in 'Reject Code' (511-FB).	RW	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).

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill** **Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		3 character alphanumeric		
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 9 (Maximum count of 1 per Other Payer)	RW	Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø6 = Patient Pay Amount (5Ø5-F5) as reported by previous payer. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility.	RW	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. Required if Patient Pay Amount (5Ø5-F5) from Other Payer is greater than zero (Ø).
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer as found in Patient Pay Amount (5Ø5-F5) Format:s$$$$$$$$cc	RW	Required if necessary for patient financial responsibility only billing. Required if necessary for state/federal/regulatory agency programs. Required if Patient Pay Amount (5Ø5-F5) from Other Payer is greater than zero (Ø).

DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when a drug utilization review or professional pharmacy service event, opportunity, or information is sent in previous response.

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Counter number for each DUR/PPS set/logical grouping. Maximum of 9 occurrences	RW	Required if DUR/PPS Segment is used.
439-E4	REASON FOR SERVICE CODE	DD = Drug/Drug Interaction ER = Early Refill HD = High Dose LD = Low Dose LR = Late Refill MC = Drug/Disease (Reported) PA = Drug/Age PG = Drug/Pregnancy TD = Therapeutic	RW	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.
44Ø-E5	PROFESSIONAL SERVICE CODE	ØØ = No intervention MØ = Prescriber consulted MA = Medication Administration PØ = Patient consulted RØ = Pharmacist consulted other source	RW	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. Use MA for vaccine administration.

441-E6	RESULT OF SERVICE CODE	ØØ = Not specified 1A = Filled as is, false positive 1B = Filled prescription as is 1C = Filled, with different dose 1D = Filled, with different directions 1E = Filled, with different drug 1F = Filled, with different quantity 1G = Filled, with prescriber approval 1H = Brand-to-Generic change 1J = Rx-to-OTC change 1K = Filled, with different dosage form 2A = Prescription not filled 2B = Not filled, directions clarified 3A = Recommendation accepted 3B = Recommendation not accepted 3C = Discontinued drug 3D = Regimen changed 3E = Therapy changed 3F = Therapy changed-Cost increase acknowledged 3G = Drug therapy unchanged 3H = Follow-up report 3J = Patient referral 3K = Instructions understood 3M = Compliance aid provided 3N = Medication administered	RW	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.

Compound Segment Questions	**Check**	**Claim Billing/Claim Rebill** **If Situational, *Payer Situation***
This Segment is always sent		
This Segment is situational	X	Required when Compound Code (4Ø6-D6) = 2 (compound). Required when submitting for a multi-ingredient prescription.

	Compound Segment **Segment Identification (111-AM) = "1Ø"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	Dosage form of the complete compound mixture. NCI values of Diagnostic, Therapeutic, and Research Equipment - Pharmaceutical Dosage Form For NCPDP Specific Terminology	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	1 = Each 2 = Grams 3 = Milliliters	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Count of compound product IDs (both active and inactive) in the compound mixture submitted. Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3 = National Drug Code (NDC)	M	
489-TE	COMPOUND PRODUCT ID	11 digit NDC	M	
448-ED	COMPOUND INGREDIENT QUANTITY	Format=9999999.999	M	
449-EE	COMPOUND INGREDIENT DRUG		RW	Required if needed for receiver claim determination when multiple products are billed.
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION		RW	Required if needed for receiver claim determination when multiple products are billed.
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Maximum count of 1Ø.	RW	Required when Compound Ingredient Modifier Code (363-2H) is sent
363-2H	COMPOUND INGREDIENT MODIFIER CODE		RW	Required if necessary for state/federal/regulatory agency programs.

Clinical Segment Questions	**Check**	**Claim Billing/Claim Rebill** **If Situational, *Payer Situation***
This Segment is always sent		
This Segment is situational	X	Required when necessary to specify clinical diagnosis information associated with the Claim Billing transaction.

	Clinical Segment **Segment Identification (111-AM) = "13"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Count of diagnosis occurrences. Maximum count of 5	RW	Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.
492-WE	DIAGNOSIS CODE QUALIFIER	ØØ = Not Specified Ø1 = International Classification of Diseases (ICD9) Ø2 = International Classification of Diseases-1Ø-Clinical	RW	Required if Diagnosis Code (424-DO) is used.

	Clinical Segment **Segment Identification (111-AM) = "13"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		Modifications (ICD-1Ø-CM)		
424-DO	DIAGNOSIS CODE		RW	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.

**** End of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet ****

Response Claim Billing/Claim Rebill Payer Sheet

**** Start of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet****

Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) Response

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

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Billing/Claim Rebill – 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, B3	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 Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill – 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	15 character RxCLAIM number assigned to each transaction		Required if needed to identify the transaction.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Count of the 'Additional Message Information' (526-FQ) occurrences that follow. Maximum count of 9		Required if Additional Message Information (526-FQ) is used.

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Used for free form text with no pre-defined structure. Ø1 = first line Ø2 = second line Ø3 = third line Ø4 = fourth line Ø5 = fifth line Ø6 = sixth line Ø7 = seventh line Ø8 = eighth line Ø9 = ninth line		Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION	Free text message. Maximum 4Ø bytes		Required when additional text is needed for clarification or detail.

Response Claim Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation***
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	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	Reference number assigned by the provider for the dispensed drug/product and/or service provided 12 digit numeric	M	

Response Pricing Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation***
This Segment is always sent	X	

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø5-F5	PATIENT PAY AMOUNT	Amount Applied to Periodic Deductible (517-FH) + Amount of Copay (518-FI) = Patient Pay Amount (5Ø5-F5) Format=s$$$$$$cc	R	

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø6-F6	INGREDIENT COST PAID	Drug ingredient cost paid included in the 'Total Amount Paid' (5Ø9-F9). Format=s$$$$$$cc	R	
5Ø7-F7	DISPENSING FEE PAID	Dispensing fee paid included in the 'Total Amount Paid' (5Ø9-F9). Format=s$$$$$$cc	RW	Required if this value is used to arrive at the final reimbursement
521-FL	INCENTIVE AMOUNT PAID	Incentive amount paid included in the 'Total Amount Paid' (5Ø9-F9). Format=s$$$$$$cc	RW	Required if this value is used to arrive at the final reimbursement
557-AV	TAX EXEMPT INDICATOR	4 = Payer/Plan and Patient are Tax Exempt =Neither the payer/plan nor the patient can be charged tax.	RW	Required if the sender (health plan) and/or patient is tax exempt and exemption applies to this billing.
558-AW	FLAT SALES TAX AMOUNT PAID	Flat sales tax paid which is included in the 'Total Amount Paid' (5Ø9-F9). Format=s$$$$$$cc	RW	Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (Ø) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement.
559-AX	PERCENTAGE SALES TAX AMOUNT PAID	Amount of percentage sales tax paid which is included in the 'Total Amount Paid' (5Ø9-F9). Format=s$$$$$$cc	RW	Required if this value is used to arrive at the final reimbursement. Required if Percentage Sales Tax Amount Submitted (482-GE) is greater than zero (Ø).
563-J2	OTHER AMOUNT PAID COUNT	Count of the other amount paid occurrences. Maximum count of 3	RW	Required if Other Amount Paid (565-J4) is used.
564-J3	OTHER AMOUNT PAID QUALIFIER	Ø1 = Delivery Ø2 = Shipping Ø3 = Postage Ø4 = Administrative Ø9 = Compound Preparation Cost Paid 99 = Other	RW	Required if Other Amount Paid (565-J4) is used.
565-J4	OTHER AMOUNT PAID	Amount paid for additional costs claimed in 'Other Amount Claimed Submitted' (48Ø-H9). Format=s$$$$$$cc	RW	Required if this value is used to arrive at the final reimbursement. Required if Other Amount Claimed Submitted (48Ø-H9) is greater than zero (Ø).
566-J5	OTHER PAYER AMOUNT RECOGNIZED	Total amount recognized by the processor of any payment from another source. Format=s$$$$$$cc	RW	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.

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø9-F9	TOTAL AMOUNT PAID	Total amount to be paid by the claims processor Ingredient Cost Paid (5Ø6-F6) + Dispensing Fee Paid (5Ø7-F7) + Incentive Amount Paid (521-FL) + Other Amount Paid (565-J4) + Flat Sales Tax Amount Paid (558-AW) + Percentage Sales Tax Amount Paid (559-AX) - Patient Pay Amount (5Ø5-F5) - Other Payer Amount Recognized (566-J5) ---------- = Total Amount Paid (5Ø9-F9) Format=s$$$$$$cc	R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	4 = Usual & Customary paid as submitted 5 = Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary 14 = Other Payer-Patient Responsibility Amount 15 = Patient Pay Amount	RW	Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing.
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	Amount to be collected from a patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is applied to a periodic deductible (Spenddown). Format=s$$$$$$cc	RW	Required if Patient Pay Amount (5Ø5-F5) includes deductible
518-FI	AMOUNT OF COPAY	Amount to be collected from the patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is due to a per prescription copay. Format=s$$$$$$cc	RW	Required if Patient Pay Amount (5Ø5-F5) includes copay as patient financial responsibility.
148-U8	INGREDIENT COST CONTRACTED/REIMBURSABLE AMOUNT		RW	Required when a Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount" or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency.
149-U9	DISPENSING FEE CONTRACTED/REIMBURSABLE AMOUNT		RW	Required when a Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount" or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency.

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	The segment is used to identify a drug utilization review or professional pharmacy service event, opportunity, or information.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Counter number for each DUR/PPS response set/logical grouping. Maximum 9 occurrences supported.	RW	Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE	DD = Drug/Drug Interaction ER = Early Refill HD = High Dose LD = Low Dose LR = Late Refill MC =– Drug/Disease (Reported) PA = Drug/Age PG =– Drug/Pregnancy TD = Therapeutic	RW	Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE	Blank = Not Specified 1 = Major 2 = Moderate 3 = Minor	RW	Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR	Ø = Not Specified 1 = Your Pharmacy 2 = Other Pharmacy in Same Chain 3 = Other Pharmacy	RW	Required if needed to supply additional information for the utilization conflict.
53Ø-FU	PREVIOUS DATE OF FILL	Date prescription was previously filled. Format=CCYYMMDD	RW	Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used.
531-FV	QUANTITY OF PREVIOUS FILL	Amount expressed in metric decimal units of the conflicting agent that was previously filled. Format=9999999.999	RW	Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used.
533-FX	OTHER PRESCRIBER INDICATOR	Ø = Not Specified 1 = Same Prescriber 2 = Other Prescriber	RW	Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE	Text that provides additional detail regarding a DUR conflict.	RW	Required if needed to supply additional information for the utilization conflict.

Claim Billing/Claim Rebill Accepted/Rejected Response

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Billing/Claim Rebill Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	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 Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER	15 character RxCLAIM number assigned to each transaction	RW	Required if needed to identify the transaction.
51Ø-FA	REJECT COUNT	Count of 'Reject Code' (511-FB) occurrences. Maximum count of 5	R	
511-FB	REJECT CODE	See National Council on Prescription Drug Programs (NCPDP) External Code List.	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	RW	Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Count of the 'Additional Message Information' (526-FQ) occurrences that follow. Maximum count of 9	RW	Required if Additional Message Information (526-FQ) is used.

	Response Status Segment **Segment Identification (111-AM) = "21"**			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Used for free form text with no pre-defined structure. Ø1 = first line Ø2 = second line Ø3 = third line Ø4 = fourth line Ø5 = fifth line Ø6 = sixth line Ø7 = seventh line Ø8 = eighth line Ø9 = ninth line	RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION	Free text message. Maximum 4Ø bytes	RW	Required when additional text is needed for clarification or detail.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3 = Processor/PBM	RW	Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER	Ten-digit phone number of the help desk. 855-577-6317	RW	Required if needed to provide a support telephone number to the receiver.

Response Claim Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** **If Situational, *Payer Situation***
This Segment is always sent	X	

	Response Claim Segment **Segment Identification (111-AM) = "22"**			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	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	Reference number assigned by the provider for the dispensed drug/product and/or service provided 12 digit numeric	M	

Response DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** **If Situational, *Payer Situation***
This Segment is always sent		
This Segment is situational	X	The segment is used to identify a drug utilization review or professional pharmacy service event, opportunity, or information.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing/Claim Rebill – Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Counter number for each DUR/PPS response set/logical grouping. Maximum 9 occurrences supported.	RW	Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE	DD = Drug/Drug Interaction ER = Early Refill HD = High Dose LD = Low Dose LR = Late Refill MC =– Drug/Disease (Reported) PA = Drug/Age PG =– Drug/Pregnancy TD = Therapeutic	RW	Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE	Blank = Not Specified 1 = Major 2 = Moderate 3 = Minor	RW	Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR	Ø = Not Specified 1 = Your Pharmacy 2 = Other Pharmacy in Same Chain 3 = Other Pharmacy	RW	Required if needed to supply additional information for the utilization conflict.
53Ø-FU	PREVIOUS DATE OF FILL	Date prescription was previously filled. Format=CCYYMMDD	RW	Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used.
531-FV	QUANTITY OF PREVIOUS FILL	Amount expressed in metric decimal units of the conflicting agent that was previously filled. Format=9999999.999	RW	Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used.
533-FX	OTHER PRESCRIBER INDICATOR	Ø = Not Specified 1 = Same Prescriber 2 = Other Prescriber	RW	Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE	Text that provides additional detail regarding a DUR conflict.		Required if needed to supply additional information for the utilization conflict.

Claim Billing/Claim Rebill Rejected/Rejected Response

Response Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill Rejected/Rejected** **If Situational, *Payer Situation***
This Segment is always sent	X	

	Response Transaction Header Segment			**Claim Billing/Claim Rebill Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	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 Status Segment Questions	**Check**	**Claim Billing/Claim Rebill Rejected/Rejected If Situational, *Payer Situation***
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER	15 character RxCLAIM number assigned to each transaction.	RW	Required if needed to identify the transaction.
51Ø-FA	REJECT COUNT	Count of 'Reject Code' (511-FB) occurrences. Maximum count of 5.	R	
511-FB	REJECT CODE	See National Council on Prescription Drug Programs (NCPDP) External Code List	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	RW	Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Count of the 'Additional Message Information' (526-FQ) occurrences that follow. Maximum count of 9.	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Used for free form text with no pre-defined structure. Ø1 = first line Ø2 = second line Ø3 = third line Ø4 = fourth line Ø5 = fifth line Ø6 = sixth line Ø7 = seventh line Ø8 = eighth line Ø9 = ninth line	RW	Required if Additional Message Information (526-FQ) is used.

	Response Status Segment **Segment Identification (111-AM) = "21"**			**Claim Billing/Claim Rebill** **Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
526-FQ	ADDITIONAL MESSAGE INFORMATION	Free text message. Maximum 4Ø bytes	RW	Required when additional text is needed for clarification or detail.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3 = Processor/PBM	RW	Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER	Ten-digit phone number of the help desk. 855-577-6317	RW	Required if needed to provide a support telephone number to the receiver.

**** End of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet****

Section 2: NCPDP Version D.Ø Claim Reversal

Request Claim Reversal Payer Sheet

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

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
NOT USED	NA	The Field is not used for the Segment in the designated Transaction. Not used are shaded for clarity for the Payer when creating the Template. For the actual Payer Template, not used fields must be deleted from the transaction (the row in the table removed).	No

Question	Answer
What is your reversal window?	Point-of-sale, immediate

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

Claim Reversal Transaction

Transaction Header Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs 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	ØØ1553	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	INM	M	
1Ø9-A9	TRANSACTION COUNT	1 = One occurrence 2 = Two occurrences 3 = Three occurrences 4 = Four occurrences Maximum of one allowed for compound transactions	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider Identifier (NPI)	M	
2Ø1-B1	SERVICE PROVIDER ID	1Ø digit NPI	M	
4Ø1-D1	DATE OF SERVICE	Format=CCYYMMDD	M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	ID assigned by the switch or processor to identify the software source. 1Ø character alphanumeric	M	

Claim Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*
This Segment is always sent	X	

	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	Ø1 = Rx Billing	M	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	Reference 12 digit number assigned by the provider for the dispensed drug/product and/or service provided 12 digit numeric	M	

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
436-E1	PRODUCT/SERVICE ID QUALIFIER	ØØ = Compound Ø3 = National Drug Code (NDC)	M	
4Ø7-D7	PRODUCT/SERVICE ID	NDC (Drug Code) 11 characters	M	

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

Response Claim Reversal Payer Sheet Template

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

Claim Reversal Accepted/Approved Response

General Information

Payer Name: Indiana Medicaid	Date: April 1, 2013
BIN: ØØ1553	PCN: INM

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

Response Transaction Header Segment Questions	**Check**	**Claim Reversal – Accepted/Approved If Situational, *Payer Situation***
This Segment is always sent	X	

	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 Status Segment Questions	**Check**	**Claim Reversal – Accepted/Approved If Situational, *Payer Situation***
This Segment is always sent	X	

	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	15 character RxCLAIM number assigned to each transaction.	RW	Required if needed to identify the transaction.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Count of the 'Additional Message Information' (526-FQ) occurrences that follow. Maximum count of 9.	RW	Required if Additional Message Information (526-FQ) is used.

	Response Status Segment **Segment Identification (111-AM) = "21"**			**Claim Reversal – Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Used for free form text with no pre-defined structure. Ø1 = first line Ø2 = second line Ø3 = third line Ø4 = fourth line Ø5 = fifth line Ø6 = sixth line Ø7 = seventh line Ø8 = eighth line Ø9 = ninth line	RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION	Free text message. Maximum 4Ø bytes	RW	Required when additional text is needed for clarification or detail.

Response Claim Segment Questions	**Check**	**Claim Reversal – Accepted/Approved** **If Situational, *Payer Situation***
This Segment is always sent	X	

	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 = RxBilling	M	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	Reference 12 digit number assigned by the provider for the dispensed drug/product and/or service provided	M	

Claim Reversal Accepted/Rejected Response

Response Transaction Header Segment Questions	**Check**	**Claim Reversal - Accepted/Rejected** **If Situational, *Payer Situation***
This Segment is always sent	X	

	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	

	Response Transaction Header Segment			**Claim Reversal – Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	**Check**	**Claim Reversal - Accepted/Rejected If Situational, *Payer Situation***
This Segment is always sent	X	

	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	15 character RxCLAIM number assigned to each transaction	R	
51Ø-FA	REJECT COUNT	Count of 'Reject Code' (511-FB) occurrences. Maximum count of 5.	R	
511-FB	REJECT CODE	See National Council on Prescription Drug Programs (NCPDP) External Code List	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	RW	Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Count of the 'Additional Message Information' (526-FQ) occurrences that follow. Maximum count of 9.	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Used for free form text with no pre-defined structure. Ø1 = first line Ø2 = second line Ø3 = third line Ø4 = fourth line Ø5 = fifth line Ø6 = sixth line Ø7 = seventh line Ø8 = eighth line Ø9 = ninth line	RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION	Free text message. Maximum 4Ø bytes	RW	Required when additional text is needed for clarification or detail.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3 = Processor/PBM	RW	Required if Help Desk Phone Number (55Ø-8F) is used.

	Response Status Segment **Segment Identification (111-AM) = "21"**			**Claim Reversal – Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
55Ø-8F	HELP DESK PHONE NUMBER	Ten-digit phone number of the help desk. 855-577-6317	RW	Required if needed to provide a support telephone number to the receiver.

Response Claim Segment Questions	**Check**	**Claim Reversal - Accepted/Rejected** **If Situational, *Payer Situation***
This Segment is always sent	X	

	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 = RxBilling	M	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	Reference 12 digit number assigned by the provider for the dispensed drug/product and/or service provided	M	

Claim Reversal Rejected/Rejected Response

Response Transaction Header Segment Questions	**Check**	**Claim Reversal - Rejected/Rejected** **If Situational, *Payer Situation***
This Segment is always sent	X	

	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 Status Segment Questions	**Check**	**Claim Reversal - Rejected/Rejected** **If Situational, *Payer Situation***
This Segment is always sent	X	

	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	15 character RxCLAIM number assigned to each transaction	R	
51Ø-FA	REJECT COUNT	Count of 'Reject Code' (511-FB) occurrences. Maximum count of 5.	R	
511-FB	REJECT CODE	See National Council on Prescription Drug Programs (NCPDP) External Code List	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	RW	Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Count of the 'Additional Message Information' (526-FQ) occurrences that follow. Maximum count of 9.	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Used for free form text with no pre-defined structure. Ø1 = first line Ø2 = second line Ø3 = third line Ø4 = fourth line Ø5 = fifth line Ø6 = sixth line Ø7 = seventh line Ø8 = eighth line Ø9 = ninth line	RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION	Free text message. Maximum 4Ø bytes	RW	Required when additional text is needed for clarification or detail.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3 = Processor/PBM	RW	Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER	Ten-digit phone number of the help desk. 855-577-6317	RW	Required if needed to provide a support telephone number to the receiver.

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

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