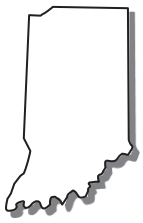
OptumRx Pharmacy Unit



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 |
| Version 9.0 | 06/01/21 | 1-12 | Updated Compound Segment | Pharmacy/Publications |
| Version 10.0 | 03/17/22 | 1-6 | Updated Level of Service (418-DI)<br>Updated Submission Clarification Code (42Ø-DK) | Pharmacy/Publications |
| Version 11.0 | 09/21/23 | 1-3, 1-4 | Added Place of Service (307-C7) field and values | Pharmacy/Publications |
| Version 12.0 | 07/09/24 | 1-3 | Added Patient Residence (384-4X) values | Pharmacy/Publications |

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# *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<br>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<br>2 = Two occurrences<br>3 = Three occurrences<br>4 = Four occurrences<br>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.<br><br>1Ø character alphanumeric | M | |

| Insurance Segment Questions | Check | Claim Billing/Claim Rebill<br>If Situational, *Payer Situation* |
|---|---|---|
| This Segment is always sent | X | |

| | Insurance Segment<br>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<br>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<br>1 = Male<br>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<br><br>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. |
| 307-C7 | PLACE OF SERVICE | Ø1 = Pharmacy | R | Indicates whether the member received pharmacy services.<br><br>On D.0 claims, the Customer Location code field is removed and instead replaced with two fields: Patient Residence and Place of Service. |
| 384-4X | PATIENT RESIDENCE | 1 = Home<br>2 = Skilled Nursing Facility.<br>3 = Nursing Facility<br>4 = Assisted Living Facility<br>5 = Custodial Care Facility<br>6 = Group Home<br>7 = Inpatient Psychiatric Facility<br>9 = Intermediate Care Facility/Mentally Retarded<br>10 = Residential Substance Treatment Facility<br>11 = Hospice<br>12 = Psychiatric Residential Treatment Facility<br>13 = Comprehensive Inpatient Rehabilitation Facility<br><br>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).<br><br>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<br><br>12 digit numeric | M | |
| 436-E1 | PRODUCT/SERVICE ID QUALIFIER | ØØ = Compound | M | |

| | **Claim Segment**<br>**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<br><br>Format=9999999.999 | R | |
| 4Ø3-D3 | FILL NUMBER | ØØ = Original dispensing<br>Ø1–99 = Refill number | R | |
| 4Ø5-D5 | DAYS SUPPLY | Estimated number of days the prescription will last.<br><br>3 digit numeric | R | |
| 4Ø6-D6 | COMPOUND CODE | 1 = Not a compound<br>2 = Compound | R | |
| 4Ø8-D8 | DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE | Code indicating whether the prescriber's instructions regarding generic substitution were followed.<br><br>Ø = No Product Selection Indicated<br>1 = Substitution Not Allowed by Prescriber<br>2 = Substitution Allowed-Patient Requested Product Dispensed<br>3 = Substitution Allowed-Pharmacist Selected Product Dispensed<br>4 = Substitution Allowed-Generic Drug Not in Stock<br>5 = Substitution Allowed-Brand Drug Dispensed as a Generic<br>8 = Substitution Allowed-Generic Drug Not Available in Marketplace<br>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<br>01 - 99, with 99 as unlimited refills | R | |
| 419-DJ | PRESCRIPTION ORIGIN CODE | 0=Not known<br>1=Written<br>2=Telephone<br>3=Electronic<br>4=Facsimile<br>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<br>Ø6 = Starter Dose<br>Ø7 = Medically Necessary<br>Ø8 = Process compound for approved ingredients<br>1Ø = Meets Plan Limitations<br>2Ø = 340B Claim<br>42 = Prescriber ID Validated | RW | Required if clarification is needed and value submitted is greater than zero (Ø).<br><br>Ø8 = Used to indicate that the provider agrees to be reimbursed for only the approved products within a compound<br><br>2Ø = Used if the product on the claim was dispensed from 340B stock<br><br>*Declared Emergency Situations: Specific values required as follows:*<br><br>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<br><br>Ø6 = 'Used when indicating that the previous medication was a starter dose and now additional medication is needed to continue treatment,' to indicate the second dose or final dose of a two-dose COVID-19 vaccine is being administered.<br><br>Ø7 = 'Used when indicating that the previous medication was a second dose and now additional medication is needed to continue treatment,' to indicate the third dose* or booster dose of a multiple-dose COVID-19 vaccine is being administered.<br><br>1Ø = 'Used when indicating that the previous medication was a second dose and now additional medication is needed to continue treatment,' to indicate the third dose* or booster dose of a multiple-dose COVID-19 vaccine is being administered.<br><br>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<br><br>*For moderately to severely immunocompromised members |
| 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<br>1 = No other coverage - Code used in coordination of benefits transactions to convey that no other coverage is available.<br>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.<br><br>Required if member has other insurance. Medicaid is payer of last resort. |

| | **Claim Segment**<br>**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.<br>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.<br>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<br>Ø3 = Emergency<br>11 = Level 1<br>12 = Level 2 | RW | Required if this field could result in different coverage, pricing, or patient financial responsibility.<br><br>Must be submitted with a maximum of 4 day supply to provide emergency override.<br><br>11 = Used if MME (Morphine Milligram Equivalent) limit is exceeded. This override should only be applied to short-acting opioid claim. Maximum of a 30-day supply per 180 days.<br><br>12 = Used if MMED (Morphine Milligram Equivalent) limit is exceeded. This override should only be applied to long-acting opioid claim. Maximum of 30-day supply per 180 days. |
| 462-EV | PRIOR AUTHORIZATION NUMBER SUBMITTED | Prior authorization number | RW | Required when known |

| **Pricing Segment Questions** | **Check** | **Claim Billing/Claim Rebill**<br>**If Situational, *Payer Situation*** |
|---|---|---|
| This Segment is always sent | X | |

| | **Pricing Segment**<br>**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.<br><br>Format=s$$$$$$cc | R | This amount is included in the 'Gross Amount Due' (43Ø-DU).<br>340B claims – submit 340B cost here with the Basis of Cost Determination (423-DN) indicator of 'Ø8'<br>Free product or no associated cost – submit cost here with the Basis of Cost Determination (423-DN) indicator of '15' |
| 412-DC | DISPENSING FEE SUBMITTED | Dispensing fee submitted by the pharmacy.<br>Format=s$$$$$$cc | RW | Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. |
| 438-E3 | INCENTIVE AMOUNT SUBMITTED | Amount represents a fee that is submitted by the pharmacy for contractually agreed upon services.<br><br>Format=s$$$$$$cc | RW | Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.<br><br>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**<br>**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<br>Ø2 = Shipping Cost<br>Ø3 = Postage Cost<br>Ø4 = Administrative Cost<br>Ø9 = Compound Preparation Cost Submitted<br>99 = Other - Different from those implied or specified | RW | Required if Other Amount Claimed Submitted (48Ø-H9) is used.<br><br>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.<br><br>Format=s$$$$$$cc | RW | Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.<br><br>Indiana Health Coverage Programs does not reimburse providers for any of the services billed in the OTHER AMOUNT CLAIMED SUBMITTED field. |
| 481-HA | FLAT SALES TAX AMOUNT SUBMITTED | Format=s$$$$$$c | RW | Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.<br><br>Indiana Health Coverage Programs does not reimburse providers for any sales tax on drugs dispensed by a registered pharmacist or licensed practitioner |
| 482-GE | PERCENTAGE SALES TAX AMOUNT SUBMITTED | Format=s$$$$$$cc | RW | Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.<br><br>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.<br><br>Required if this field could result in different pricing.<br><br>Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).<br><br>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<br>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.<br><br>Required if this field could result in different pricing.<br><br>Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX). |

| | **Pricing Segment**<br>**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$$$$$$cc | R | Required if needed per trading partner agreement.<br><br>Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed. |
| 43Ø-DU | GROSS AMOUNT DUE | Total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (4Ø9-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (48Ø-H9).<br><br>Format=s$$$$$$cc | R | |
| 423-DN | BASIS OF COST DETERMINATION | ØØ = Default<br>Ø1 = AWP<br>Ø2 = Local wholesaler<br>Ø3 = Direct<br>Ø4 = EAC<br>Ø5 = Acquisition<br>Ø6 = MAC<br>6X = Brand medically necessary<br>Ø7 = Usual and customary<br>Ø8 = 340B/Disproportionate Share Pricing/Public Health Service<br>Ø9 = Other<br>15 = Free product / no cost | | Required for all claims**.** |

| **Prescriber Segment Questions** | **Check** | **Claim Billing/Claim Rebill**<br>**If Situational, *Payer Situation*** |
|---|---|---|
| This Segment is always sent | X | |

| | **Prescriber Segment**<br>**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.<br><br>Required if necessary for state/federal/regulatory agency programs.<br><br>*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**<br>**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**<br>**Segment Identification (111-AM) = "Ø5"** | | | **Claim Billing/Claim Rebill**<br><br>**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.<br><br>Maximum count of 9 | M | |
| 338-5C | OTHER PAYER COVERAGE TYPE | Blank = Not Specified<br>Ø1 = Primary – First<br>Ø2 = Secondary – Second<br>Ø3 = Tertiary – Third<br>Ø4 = Quaternary – Fourth<br>Ø5 = Quinary – Fifth<br>Ø6 = Senary – Sixth<br>Ø7 = Septenary - Seventh<br>Ø8 = Octonary – Eighth<br>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.<br><br>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.<br><br>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<br>Ø2 = Shipping<br>Ø3 = Postage<br>Ø4 = Administrative<br>Ø5 = Incentive<br>Ø6 = Cognitive Service<br>Ø7 = Drug Benefit<br>Ø9 = Compound Preparation Cost<br>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.<br><br>Format=s$$$$$$cc | RW | Required if other payer has approved payment for some/all of the billing.<br><br>Not used for patient financial responsibility only billing.<br><br>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**<br>**Segment Identification (111-AM) = "Ø5"** | | | **Claim Billing/Claim Rebill**<br><br>**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.<br><br>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)<br><br>Format:s$$$$$$$$cc | RW | Required if necessary for patient financial responsibility only billing.<br><br>Required if necessary for state/federal/regulatory agency programs.<br><br>Required if Patient Pay Amount (5Ø5-F5) from Other Payer is greater than zero (Ø). |

| DUR/PPS Segment Questions | Check | Claim Billing/Claim Rebill<br>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<br>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.<br><br>Maximum of 9 occurrences | RW | Required if DUR/PPS Segment is used. |
| 439-E4 | REASON FOR SERVICE CODE | DD = Drug/Drug Interaction<br>ER = Early Refill<br>HD = High Dose<br>LD = Low Dose<br>LR = Late Refill<br>MC = Drug/Disease (Reported)<br>PA = Drug/Age<br>PG = Drug/Pregnancy<br>TD = Therapeutic | RW | Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.<br><br>Required if this field affects payment for or documentation of professional pharmacy service. |
| 44Ø-E5 | PROFESSIONAL SERVICE CODE | ØØ = No intervention<br>MØ = Prescriber consulted<br>MA = Medication Administration<br>PØ = Patient consulted<br>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.<br><br>Required if this field affects payment for or documentation of professional pharmacy service.<br><br>Use MA for vaccine administration. |

| | | | | |
|---|---|---|---|---|
| 441-E6 | RESULT OF SERVICE CODE | ØØ = Not specified<br>1A = Filled as is, false positive<br>1B = Filled prescription as is 1C = Filled, with different dose<br>1D = Filled, with different directions<br>1E = Filled, with different drug<br>1F = Filled, with different quantity<br>1G = Filled, with prescriber approval<br>1H = Brand-to-Generic change<br>1J = Rx-to-OTC change<br>1K = Filled, with different dosage form<br>2A = Prescription not filled<br>2B = Not filled, directions clarified<br>3A = Recommendation accepted<br>3B = Recommendation not accepted<br>3C = Discontinued drug<br>3D = Regimen changed<br>3E = Therapy changed<br>3F = Therapy changed-Cost increase acknowledged<br>3G = Drug therapy unchanged<br>3H = Follow-up report<br>3J = Patient referral<br>3K = Instructions understood<br>3M = Compliance aid provided<br>3N = Medication administered | RW | Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.<br><br>Required if this field affects payment for or documentation of professional pharmacy service. |

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

| | **Compound Segment**<br>**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.<br>NCI values of Diagnostic, Therapeutic, and Research Equipment - Pharmaceutical Dosage Form<br><br>For NCPDP Specific Terminology | M | |
| 451-EG | COMPOUND DISPENSING UNIT FORM INDICATOR | 1 = Each<br>2 = Grams<br>3 = Milliliters | M | |
| 447-EC | COMPOUND INGREDIENT COMPONENT COUNT | Count of compound product IDs (both active and inactive) in the compound mixture submitted.<br><br>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 COST | Format=s$$$$$$cc | R | Required when the transmission is for a compound claim with individual ingredients. |
| 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**<br>**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**<br>**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.<br><br>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<br>Ø1 = International Classification of Diseases (ICD9)<br>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.<br><br>Required if this field affects payment for professional pharmacy service.<br><br>Required if this information can be used in place of prior authorization.<br><br>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<br>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.<br><br>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.<br>Ø1 = first line<br>Ø2 = second line<br>Ø3 = third line<br>Ø4 = fourth line<br>Ø5 = fifth line<br>Ø6 = sixth line<br>Ø7 = seventh line<br>Ø8 = eighth line<br>Ø9 = ninth line | | Required if Additional Message Information (526-FQ) is used. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | Free text message.<br><br>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<br><br>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)<br>+ Amount of Copay (518-FI)<br>= Patient Pay Amount (5Ø5-F5)<br><br>Format=s$$$$$$cc | R | |

| | **Response Pricing Segment**<br>**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).<br><br>Format=s$$$$$$cc | R | |
| 5Ø7-F7 | DISPENSING FEE PAID | Dispensing fee paid included in the 'Total Amount Paid' (5Ø9-F9).<br><br>Format=s$$$$$$cc | RW | Required if this value is used to arrive at the final reimbursement |
| 521-FL | INCENTIVE AMOUNT PAID | Incentive amount paid included in the 'Total Amount Paid' (5Ø9-F9).<br><br>Format=s$$$$$$cc | RW | Required if this value is used to arrive at the final reimbursement |
| 557-AV | TAX EXEMPT INDICATOR | 4 = Payer/Plan and Patient are Tax Exempt =Neither the payer/plan nor the patient can be charged tax. | RW | Required if the sender (health plan) and/or patient is tax exempt and exemption applies to this billing. |
| 558-AW | FLAT SALES TAX AMOUNT PAID | Flat sales tax paid which is included in the 'Total Amount Paid' (5Ø9-F9).<br><br>Format=s$$$$$$cc | RW | Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (Ø) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement. |
| 559-AX | PERCENTAGE SALES TAX AMOUNT PAID | Amount of percentage sales tax paid which is included in the 'Total Amount Paid' (5Ø9-F9).<br><br>Format=s$$$$$$cc | RW | Required if this value is used to arrive at the final reimbursement.<br><br>Required if Percentage Sales Tax Amount Submitted (482-GE) is greater than zero (Ø). |
| 563-J2 | OTHER AMOUNT PAID COUNT | Count of the other amount paid occurrences.<br><br>Maximum count of 3 | RW | Required if Other Amount Paid (565-J4) is used. |
| 564-J3 | OTHER AMOUNT PAID QUALIFIER | Ø1 = Delivery<br>Ø2 = Shipping<br>Ø3 = Postage<br>Ø4 = Administrative<br>Ø9 = Compound Preparation Cost Paid<br>99 = Other | RW | Required if Other Amount Paid (565-J4) is used. |
| 565-J4 | OTHER AMOUNT PAID | Amount paid for additional costs claimed in 'Other Amount Claimed Submitted' (48Ø-H9).<br><br>Format=s$$$$$$cc | RW | Required if this value is used to arrive at the final reimbursement.<br><br>Required if Other Amount Claimed Submitted (48Ø-H9) is greater than zero (Ø). |
| 566-J5 | OTHER PAYER AMOUNT RECOGNIZED | Total amount recognized by the processor of any payment from another source.<br><br>Format=s$$$$$$cc | RW | Required if this value is used to arrive at the final reimbursement.<br><br>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**<br>**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<br>Ingredient Cost Paid (5Ø6-F6)<br>+ Dispensing Fee Paid (5Ø7-F7)<br>+ Incentive Amount Paid (521-FL)<br>+ Other Amount Paid (565-J4)<br>+ Flat Sales Tax Amount Paid (558-AW)<br>+ Percentage Sales Tax Amount Paid (559-AX)<br>- Patient Pay Amount (5Ø5-F5)<br>- Other Payer Amount Recognized (566-J5)<br>----------<br>= Total Amount Paid (5Ø9-F9)<br><br>Format=s$$$$$$cc | R | |
| 522-FM | BASIS OF REIMBURSEMENT DETERMINATION | 4 = Usual & Customary paid as submitted<br>5 = Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary<br>14 = Other Payer-Patient Responsibility Amount<br>15 = Patient Pay Amount | RW | Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø).<br><br>Required if Basis of Cost Determination (432-DN) is submitted on billing. |
| 517-FH | AMOUNT APPLIED TO PERIODIC DEDUCTIBLE | Amount to be collected from a patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is applied to a periodic deductible (Spenddown).<br><br>Format=s$$$$$$cc | RW | Required if Patient Pay Amount (5Ø5-F5) includes deductible |
| 518-FI | AMOUNT OF COPAY | Amount to be collected from the patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is due to a per prescription copay.<br><br>Format=s$$$$$$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<br>Accepted/Paid (or Duplicate of Paid)<br>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<br>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.<br><br>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<br>ER = Early Refill<br>HD = High Dose<br>LD = Low Dose<br>LR = Late Refill<br>MC =– Drug/Disease (Reported)<br>PA = Drug/Age<br>PG =– Drug/Pregnancy<br>TD = Therapeutic | RW | Required if utilization conflict is detected. |
| 528-FS | CLINICAL SIGNIFICANCE CODE | Blank = Not Specified<br>1 = Major<br>2 = Moderate<br>3 = Minor | RW | Required if needed to supply additional information for the utilization conflict. |
| 529-FT | OTHER PHARMACY INDICATOR | Ø = Not Specified<br>1 = Your Pharmacy<br>2 = Other Pharmacy in Same Chain<br>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.<br><br>Format=CCYYMMDD | RW | Required if needed to supply additional information for the utilization conflict.<br><br>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.<br><br>Format=9999999.999 | RW | Required if needed to supply additional information for the utilization conflict.<br><br>Required if Previous Date Of Fill (53Ø-FU) is used. |
| 533-FX | OTHER PRESCRIBER INDICATOR | Ø = Not Specified<br>1 = Same Prescriber<br>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<br>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<br>If Situational, *Payer Situation* |
|---|---|---|
| This Segment is always sent | X | |

| | Response Status Segment<br>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.<br><br>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.<br><br>Maximum count of 9 | RW | Required if Additional Message Information (526-FQ) is used. |

| | **Response Status Segment**<br>**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.<br>Ø1 = first line<br>Ø2 = second line<br>Ø3 = third line<br>Ø4 = fourth line<br>Ø5 = fifth line<br>Ø6 = sixth line<br>Ø7 = seventh line<br>Ø8 = eighth line<br>Ø9 = ninth line | RW | Required if Additional Message Information (526-FQ) is used. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | Free text message.<br><br>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.<br><br>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**<br>**If Situational, *Payer Situation*** |
|---|---|---|
| This Segment is always sent | X | |

| | **Response Claim Segment**<br>**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<br><br>12 digit numeric | M | |

| **Response DUR/PPS Segment Questions** | **Check** | **Claim Billing/Claim Rebill Accepted/Rejected**<br>**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.<br><br>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<br>ER = Early Refill<br>HD = High Dose<br>LD = Low Dose<br>LR = Late Refill<br>MC =– Drug/Disease (Reported)<br>PA = Drug/Age<br>PG =– Drug/Pregnancy<br>TD = Therapeutic | RW | Required if utilization conflict is detected. |
| 528-FS | CLINICAL SIGNIFICANCE CODE | Blank = Not Specified<br>1 = Major<br>2 = Moderate<br>3 = Minor | RW | Required if needed to supply additional information for the utilization conflict. |
| 529-FT | OTHER PHARMACY INDICATOR | Ø = Not Specified<br>1 = Your Pharmacy<br>2 = Other Pharmacy in Same Chain<br>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.<br><br>Format=CCYYMMDD | RW | Required if needed to supply additional information for the utilization conflict.<br><br>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.<br><br>Format=9999999.999 | RW | Required if needed to supply additional information for the utilization conflict.<br><br>Required if Previous Date Of Fill (53Ø-FU) is used. |
| 533-FX | OTHER PRESCRIBER INDICATOR | Ø = Not Specified<br>1 = Same Prescriber<br>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.<br><br>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.<br><br>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.<br>Ø1 = first line<br>Ø2 = second line<br>Ø3 = third line<br>Ø4 = fourth line<br>Ø5 = fifth line<br>Ø6 = sixth line<br>Ø7 = seventh line<br>Ø8 = eighth line<br>Ø9 = ninth line | RW | Required if Additional Message Information (526-FQ) is used. |

| | **Response Status Segment**<br>**Segment Identification (111-AM) = "21"** | | | **Claim Billing/Claim Rebill**<br>**Rejected/Rejected** |
|---|---|---|---|---|
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | Free text message.<br><br>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.<br><br>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.<br><br>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<br>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<br>2 = Two occurrences<br>3 = Three occurrences<br>4 = Four occurrences<br>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.<br><br>1Ø character alphanumeric | M | |

| Claim Segment Questions | Check | Claim Reversal<br>If Situational, *Payer Situation* |
|---|---|---|
| This Segment is always sent | X | |

| | Claim Segment<br>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<br><br>12 digit numeric | M | |

| | **Claim Segment**<br>**Segment Identification (111-AM) = "Ø7"** | | | **Claim Reversal** |
|---|---|---|---|---|
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 436-E1 | PRODUCT/SERVICE ID QUALIFIER | ØØ = Compound<br>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.<br><br>Maximum count of 9. | RW | Required if Additional Message Information (526-FQ) is used. |

| | **Response Status Segment**<br>**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.<br>Ø1 = first line<br>Ø2 = second line<br>Ø3 = third line<br>Ø4 = fourth line<br>Ø5 = fifth line<br>Ø6 = sixth line<br>Ø7 = seventh line<br>Ø8 = eighth line<br>Ø9 = ninth line | RW | Required if Additional Message Information (526-FQ) is used. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | Free text message.<br><br>Maximum 4Ø bytes | RW | Required when additional text is needed for clarification or detail. |

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

| | **Response Claim Segment**<br>**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**<br>**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.<br><br>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.<br><br>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.<br>Ø1 = first line<br>Ø2 = second line<br>Ø3 = third line<br>Ø4 = fourth line<br>Ø5 = fifth line<br>Ø6 = sixth line<br>Ø7 = seventh line<br>Ø8 = eighth line<br>Ø9 = ninth line | RW | Required if Additional Message Information (526-FQ) is used. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | Free text message.<br><br>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**<br>**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.<br><br>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**<br>**If Situational, *Payer Situation*** |
|---|---|---|
| This Segment is always sent | X | |

| | **Response Claim Segment**<br>**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**<br>**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**<br>**If Situational, *Payer Situation*** |
|---|---|---|
| This Segment is always sent | X | |

| | **Response Status Segment**<br>**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.<br><br>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.<br><br>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.<br>Ø1 = first line<br>Ø2 = second line<br>Ø3 = third line<br>Ø4 = fourth line<br>Ø5 = fifth line<br>Ø6 = sixth line<br>Ø7 = seventh line<br>Ø8 = eighth line<br>Ø9 = ninth line | RW | Required if Additional Message Information (526-FQ) is used. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | Free text message.<br><br>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.<br><br>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****

# Index