



Companion Guide: NCPDP Versions D.0 and 1.2 Transaction Payer Sheet

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1.2 Transaction Payer Sheet

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Section 1: NCPDP Version D.0 Transaction Set Information

General Transaction Formatting Information

The first segment of every transmission (request or response) is the Header Segment. This is the only segment that does not have a Segment Identification since it is a fixed field and length segment. After the Header Segment, other segments are included, according to the particular transaction type. Every other segment has an identifier to denote the particular segment for parsing. Segments may appear in any order after the Header Segment, according to whether the segment occurs at the transmission or transaction level. Segments are not allowed to repeat within a transaction. Segments may occur more than once only in a multitransaction transmission.

In the Header Segment, all fields are required positionally and filled to their maximum designation. This is a fixed segment. If a required field is not used, it must be filled with spaces or zeroes, as appropriate. The fields within the Header Segment do not use field separators.

Other segments may have both required and optional fields. Optional fields in a segment are submitted after the required fields. Both types of fields must be preceded by a field separator and the field's identifier. Optional fields may appear in any order except for those designated with a qualifier or in a repeating group. The required and optional fields may be truncated to the actual size used.

Parsing is accomplished with the use of separators. Version D.0 uses three separators.

- Segment separator Hex 1E (Dec 30)
- Group separator Hex 1D (Dec 29)
- Field separator Hex 1C (Dec 28)

A transmission consists of one or more transactions separated by group separators. All transmissions, whether for one, two, three, or four transactions, use group separators to denote the start of a transaction with the following exception: the Eligibility Verification transmission, which does not use a group separator.

Within a transaction, appropriate segments are included. Segments are delineated with the use of segment separators. Segments are also identified with the use of a Segment Identification in the first position of each segment. One or numerous segments can be included in each transaction. Field separators are used to delineate fields in the segments.

The general syntax of a transmission request and response will appear as follows:

| | |
|-------------------|--|
| Header Segment | |
| | Header Segment fields |
| Segment Separator | |
| | Required fields within segment as appropriate, with field separators |
| | Optional Segment fields with field separators |
| Segment Separator | |
| | Required fields within segment as appropriate, with field separators |
| | Optional Segment fields with field separators |
| Group Separator | |
| Segment Separator | |

| | |
|-------------------|--|
| | Required fields within segment as appropriate, with field separators |
| | Optional Segment fields with field separators |
| Segment Separator | |
| | Required fields within segment as appropriate, with field separators |
| | Optional Segment fields with field separators |

Variable Usage Guidelines

- Leading zeroes and trailing blanks can be omitted from some data fields.
- Alphanumeric fields default to spaces when empty, not null characters.
- Numeric fields default to zeroes.
- Dollar fields default to zeroes; however, dollar fields are always signed. The least significant digit of a dollar field must always be an overpunch sign, not a digit.

Overpunch Sign

The purpose of using overpunch signs in dollar fields is to allow the representation of positive and negative dollar amounts without expanding the size of the field (that is, to hold the plus or minus character).

The overpunch sign replaces the far-right character in a dollar field. The signed value designates the positive or negative status of the numeric value. The dollar field of \$99.95 would be represented as 999E with truncation.

| UNIT | SIGNED POSITIVE | | | | SIGNED NEGATIVE | | | |
|------|-----------------|-----|-----|-----|-----------------|-----|-----|-----|
| | GRAPHIC | OCT | DEC | HEX | GRAPHIC | OCT | DEC | HEX |
| 0 | { | 173 | 123 | 7B | } | 175 | 125 | 7D |
| 1 | A | 101 | 65 | 41 | J | 112 | 74 | 4A |
| 2 | B | 102 | 66 | 42 | K | 113 | 75 | AB |
| 3 | C | 103 | 67 | 43 | L | 114 | 76 | 4C |
| 4 | D | 104 | 68 | 44 | M | 115 | 77 | 4D |
| 5 | E | 105 | 69 | 45 | N | 116 | 78 | 4E |
| 6 | F | 106 | 70 | 46 | O | 117 | 79 | 4F |
| 7 | G | 107 | 71 | 47 | P | 120 | 80 | 50 |
| 8 | H | 110 | 72 | 48 | Q | 121 | 81 | 51 |
| 9 | I | 111 | 73 | 49 | R | 122 | 82 | 52 |

Note: This table shows ASCII values.

Implied Decimal Points

In the D.0 standard, only patient clinical value fields will contain decimal points. All other decimal points are implied. For example, patient diagnosis codes should be formatted with explicit decimal points.

Note: Decimal points in dollar fields are implied.

Truncation

To truncate a field using the D.0 format:

- **Numeric** (N or D): Remove leading zeroes
- **Alphanumeric** (A): Remove trailing spaces

Note: Do not truncate or eliminate any fields in the required header segments.

Transmissions

Refer to the NCPDP *Telecommunication Standard Implementation Guide Version D.0* for the structure and syntax of the transaction(s) within the transmission.

In the template, the Segment Identification (112-AM) fields are not shown. Segment, Group, and Field Separators are not shown as they are part of the syntax. These fields are not shown because they are part of the underlying structure of the transaction and are covered in the guide. This template is to show the business and plan requirements.

Field Legend

This legend is used by the Payer to determine how to complete the Payer Template for the field designations.

| Telecommunication Implementation Guide Designation | Implementation Guide Value | Explanation | Payer Sheet Value | Payer Situation Defined |
|--|----------------------------|--|---------------------|-------------------------|
| MANDATORY | M | The Field is mandatory for the Segment in the Transaction. Mandatory elements have structural requirements. | M | |
| SITUATIONAL | | The Field has been further designated as “R” or “Q”, as shown below. | | |
| Required | R | The Field has been designated with the situation of "Required" for the Segment in the designated Transaction. | R | |
| Qualified Requirement | Q | The situations designated have qualifications for usage | RW (Required When). | Yes for RW |
| INFORMATIONAL ONLY | I | The Field is for informational purposes only in the designated Transaction. For response fields, if the payer supports the business usage, the informational field should be returned. | RW (Required When). | Yes for RW |
| OPTIONAL | O | The Field has been designated as optional usage (situations were intentionally not defined). Limited usage. See requirements in NCPDP <i>Telecommunication Standard Implementation Guide</i> . | RW (Required When). | Yes for RW |

Section 2: NCPDP Version D.0 Transaction Set Specifications

Following is a list of the data elements, field names, and field positions for the Indiana Health Coverage Programs (IHCP) Pharmacy POS claims using the NCPDP Version D.0 format.

Standard COBOL documentation is used for transaction descriptions. The following definitions are given to ensure consistency of interpretation:

- **Field** – The NCPDP D.0 data element identifier for a given transaction.
- **Field Name** – The short definition, name, or literal constant of the data located within the transaction at the positions indicated.
- **Picture (Pic)** – The COBOL “PICTURE” clause that describes how the data is presented on the transmission.
 - X = An alphanumeric character
 - 9 = An alphanumeric character
 - S = An alphanumeric character
 - V = An alphanumeric character
 - () = The character in front of the left parenthesis is repeated the number of times between the parentheses; for example, X(5) represents the same PICTURE as XXXXX.
- **Type** – The type of data in the field.
 - A = Always left-justified and space filled: A–Z, 0–9, and printable characters.
 - D = Signed Numeric – Always right-justified; zero always positive; zero-filled dollar and cents amount with two positions to the right of the implied decimal point; all other positions to the left of the implied decimal point have default values of zeroes when used for dollar fields (sign is internal and trailing).
Example: A “D” field with a length of 8 is represented as \$\$\$\$\$\$cc.
 - N = Unsigned Numeric – Always right-justified and zero filled.
Format: 9(7)V999
Example: 9999999.999
- **Value** – If a particular value is expected for Rx–POS, that value is given.
- **Comments** – NCPDP vD.0 is a variable length format standard. Therefore, with the exception of the header fields (which are always required), a transaction will contain only those elements that are necessary. The “Comments” portion indicates whether a field is required and any new rules on how to bill. Required fields may be mandatory by the NCPDP D.0 standard and/or required by the processor (HP Enterprise Services).

Section 3: NCPDP Version D.0 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: September 29, 2011 |
| Plan Name/Group Name: Fee-For-Service/INCAID100 | BIN: 610467 | PCN: INCAIDPROD = production INCAIDTEST = test |
| Processor: HP Enterprise Services | | |
| Effective as of: January 1, 2012 | NCPDP Telecommunication Standard Version/Release #: D.0. | |
| NCPDP Data Dictionary Version Date: June 2010 | NCPDP External Code List Version Date: June 2010 | |
| Certification Contact Information: HPES/EDI Solutions Service Desk 317-488-5160 or 877-877-5182; or INXIXTradingPartner@hp.com | | |
| Provider Relations Help Desk Info: 1-800-577-1278 or 317-655-3240, Option 2 | | |
| Electronic Solutions Help Desk Info: 1-877-877-5182 or 317-488-5160 | | |
| Other versions supported: n/a | | |

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.0.

| 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 (110-AK) is Not used | X | |

| Field # | Transaction Header Segment NCPDP Field Name | Value | Payer Usage | Claim Billing/Claim Rebill Payer Situation |
|---------|--|--|-------------|---|
| 101-A1 | BIN NUMBER | 610467 | M | |
| 102-A2 | VERSION/RELEASE NUMBER | D0 | M | |
| 103-A3 | TRANSACTION CODE | B1, B3 | M | |
| 104-A4 | PROCESSOR CONTROL NUMBER | INCAIDPROD = production INCAIDTEST = test | M | |
| 109-A9 | TRANSACTION COUNT | 1 = One occurrence 2 = Two occurrences 3 = Three occurrences 4 = Four occurrences Maximum of one allowed for compound transactions | M | |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | 01 = National Provider Identifier (NPI) | M | |
| 201-B1 | SERVICE PROVIDER ID | 10 digit NPI | M | |
| 401-D1 | DATE OF SERVICE | Format=CCYYMMDD | M | |
| 110-AK | SOFTWARE VENDOR/CERTIFICATION ID | ID assigned by the switch or processor to identify the software source. 10 character alphanumeric | M | |

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

| Field # | Insurance Segment Segment Identification (111-AM) = "04" | Value | Payer Usage | Claim Billing/Claim Rebill Payer Situation |
|---------|---|--|-------------|---|
| 302-C2 | CARDHOLDER ID | 12 digit numeric Indiana Medicaid member ID number | M | |
| 301-C1 | GROUP ID | INCAID100 | R | Required if necessary for state/federal/regulatory agency programs. |

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

| Patient Segment Segment Identification (111-AM) = "01" | | | Claim Billing/Claim Rebill | |
|---|---------------------|--|----------------------------|---|
| Field | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| 304-C4 | DATE OF BIRTH | Format=CCYYMMDD | R | |
| 305-C5 | PATIENT GENDER CODE | Ø = Not specified/Unknown 1 = Male 2 = Female | R | |
| 310-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 | 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. | RW | Required if this field could result in different coverage, pricing, or patient financial responsibility. 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 §423.100 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 1902(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 section 1902 (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) = "07" | | | 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). |

| Claim Segment | | | | Claim Billing/Claim Rebill |
|---------------|--|---|-------------|--|
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| 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 Ø3 = National Drug Code (NDC) | M | |
| 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 or not 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 | |
| 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 | Ø8 = Process compound for | RW | Required if clarification is needed and value |

| Claim Segment | | | Claim Billing/Claim Rebill | |
|--|---------------------|---|----------------------------|--|
| Segment Identification (111-AM) = "07" | | | | |
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| | | approved ingredients | | submitted is greater than zero (0). Used to indicate that the provider agrees to be reimbursed for only the approved products within a compound |
| 308-C8 | OTHER COVERAGE CODE | 0 = 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 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. | 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. |
| 418-DI | LEVEL OF SERVICE | 00 = Not specified 03 = 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 |

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

| Pricing Segment | | | Claim Billing/Claim Rebill | |
|--|---------------------------|---|----------------------------|---|
| Segment Identification (111-AM) = "11" | | | | |
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| 409-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' (430-DU). |
| 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 (430-DU) calculation. |

| Pricing Segment | | | Claim Billing/Claim Rebill | |
|--|--|---|----------------------------|--|
| Segment Identification (111-AM) = "11" | | | | |
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| 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. Indiana Health Coverage Programs does not have any contractually agreed upon services that are reimbursed to providers |
| 478-H7 | OTHER AMOUNT CLAIMED SUBMITTED COUNT | Maximum count of 3. | RW | Required if Other Amount Claimed Submitted Qualifier (479-H8) is used. |
| 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\$\$\$\$\$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 |
| 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 |

| Pricing Segment Segment Identification (111-AM) = "11" | | | Claim Billing/Claim Rebill | |
|---|--------------------------------------|--|----------------------------|--|
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| | | | | 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). 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 | |

| 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. |

| Prescriber Segment Segment Identification (111-AM) = “Ø3” | | | Claim Billing/Claim Rebill | |
|--|------------------|-------|----------------------------|---|
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| | | | | Required if necessary for state/federal/regulatory agency programs. |

| 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 | RW | Required if Other Payer Amount Paid (431-DV) is used. |

| Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = “Ø5” | | | Claim Billing/Claim Rebill | |
|---|---|---|----------------------------|---|
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| | | Ø3 = Postage Ø4 = Administrative Ø5 = Incentive Ø6 = Cognitive Service Ø7 = Drug Benefit Ø9 = Compound Preparation Cost 1Ø = Sales Tax | | |
| 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). 3 character alphanumeric | 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). |
| 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 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. |
| 441-E6 | RESULT OF SERVICE CODE | 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 2A = Prescription not filled 2B = Not filled, directions clarified | 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. <u>NCI values of Diagnostic, Therapeutic, and Research Equipment - Pharmaceutical Dosage Form</u> <u>For NCPDP Specific Terminology</u> | 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 | |

| 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 Modifications (ICD-1Ø-CM) | RW | Required if Diagnosis Code (424-DO) is used. |
| 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. |

| Clinical Segment Segment Identification (111-AM) = "13" | | | | Claim Billing/Claim Rebill |
|--|------------------|-------|-------------|--|
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| | | | | 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.0.

| 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 |
| 102-A2 | VERSION/RELEASE NUMBER | D0 | M | |
| 103-A3 | TRANSACTION CODE | B1, B3 | M | |
| 109-A9 | TRANSACTION COUNT | Same value as in request | M | |
| 501-F1 | HEADER RESPONSE STATUS | A = Accepted | M | |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | Same value as in request | M | |
| 201-B1 | SERVICE PROVIDER ID | Same value as in request | M | |
| 401-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 | |
| 503-F3 | AUTHORIZATION NUMBER | 13 character Internal Control Number (ICN) | | Required if needed to identify the transaction. |
| 130-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) |
|----------------|---|--|------------------------|--|
| <i>Field #</i> | <i>NCPDP Field Name</i> | <i>Value</i> | <i>Payer Usage</i> | <i>Payer Situation</i> |
| 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) |
|----------------|--|--|------------------------|--|
| <i>Field #</i> | <i>NCPDP Field Name</i> | <i>Value</i> | <i>Payer Usage</i> | <i>Payer Situation</i> |
| 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) |
|----------------|--|--------------|------------------------|--|
| <i>Field #</i> | <i>NCPDP Field Name</i> | <i>Value</i> | <i>Payer Usage</i> | <i>Payer Situation</i> |
| | | | | |

| 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 |
| 505-F5 | PATIENT PAY AMOUNT | Amount Applied to Periodic Deductible (517-FH) + Amount of Copay (518-FI) = Patient Pay Amount (505-F5) Format=s\$\$\$\$\$cc | R | |
| 506-F6 | INGREDIENT COST PAID | Drug ingredient cost paid included in the 'Total Amount Paid' (509-F9). Format=s\$\$\$\$\$cc | R | |
| 507-F7 | DISPENSING FEE PAID | Dispensing fee paid included in the 'Total Amount Paid' (509-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' (509-F9). Format=s\$\$\$\$\$cc | RW | Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (0) 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' (509-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 (0). |
| 521-FL | INCENTIVE AMOUNT PAID | Amount represents the contractually agreed upon incentive fee paid for specific services rendered. Amount is included in the 'Total Amount Paid' (509-F9). Format=s\$\$\$\$\$cc | RW | Required if this value is used to arrive at the final reimbursement. Required if Incentive Amount Submitted (438-E3) is greater than zero (0). |
| 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. |

| 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 |
| 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. |
| 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 and Customary paid as submitted 5 = Paid Lower of Ingredient Cost Plus Fees Versus Usual & 14 = Other Payer-Patient Responsibility 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. |

| 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 |
| 517-FH | AMOUNT APPLIED TO PERIODIC DEDUCTIBLE | Amount to be collected from a patient that is included in 'Patient Pay Amount' (505-F5) that is applied to a periodic deductible (Spendedown). Format=s\$\$\$\$\$cc | RW | Required if Patient Pay Amount (505-F5) includes deductible |
| 518-FI | AMOUNT OF COPAY | Amount to be collected from the patient that is included in 'Patient Pay Amount' (505-F5) that is due to a per prescription copay. Format=s\$\$\$\$\$cc | RW | Required if Patient Pay Amount (505-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. |

| | Response DUR/PPS Segment Segment Identification (111-AM) = “24” | | | Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) |
|----------------|--|--|--------------------|--|
| <i>Field #</i> | <i>NCPDP Field Name</i> | <i>Value</i> | <i>Payer Usage</i> | <i>Payer Situation</i> |
| 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. |
| 532-FW | DATABASE INDICATOR | 1 = First DataBank | RW | Required if needed to supply additional information for the utilization conflict. |
| 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 | |

| Field # | Response Transaction Header Segment NCPDP Field Name | Value | Payer Usage | Claim Billing/Claim Rebill Accepted/Rejected Payer Situation |
|---------|---|--------------------------|-------------|---|
| 102-A2 | VERSION/RELEASE NUMBER | D0 | M | |
| 103-A3 | TRANSACTION CODE | B1, B3 | M | |
| 109-A9 | TRANSACTION COUNT | Same value as in request | M | |
| 501-F1 | HEADER RESPONSE STATUS | A = Accepted | M | |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | Same value as in request | M | |
| 201-B1 | SERVICE PROVIDER ID | Same value as in request | M | |
| 401-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 | |

| Field # | Response Status Segment Segment Identification (111-AM) = "21" | Value | Payer Usage | Claim Billing/Claim Rebill Accepted/Rejected Payer Situation |
|---------|---|---|-------------|--|
| 112-AN | TRANSACTION RESPONSE STATUS | R = Reject | M | |
| 503-F3 | AUTHORIZATION NUMBER | 13 character Internal Control Number (ICN) | RW | Required if needed to identify the transaction. |
| 510-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, Appendix A – Reject Codes | 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. |
| 130-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 |
|----------------|---|--|------------------------|---|
| <i>Field #</i> | <i>NCPDP Field Name</i> | <i>Value</i> | <i>Payer Usage</i> | <i>Payer Situation</i> |
| 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. 8ØØ5771278opt2 | 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 |
|----------------|--|--|------------------------|--|
| <i>Field #</i> | <i>NCPDP Field Name</i> | <i>Value</i> | <i>Payer Usage</i> | <i>Payer Situation</i> |
| 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 |
|----------------|--|--|--------------------|--|
| <i>Field #</i> | <i>NCPDP Field Name</i> | <i>Value</i> | <i>Payer Usage</i> | <i>Payer Situation</i> |
| 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. |
| 530-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 (530-FU) is used. |
| 532-FW | DATABASE INDICATOR | 1 = First DataBank | RW | Required if needed to supply additional information for the utilization conflict. |
| 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 | |

| Field # | Response Transaction Header Segment NCPDP Field Name | Value | Payer Usage | Claim Billing/Claim Rebill Rejected/Rejected 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 | |

| Field # | Response Status Segment Segment Identification (111-AM) = "21" NCPDP Field Name | Value | Payer Usage | Claim Billing/Claim Rebill Rejected/Rejected Payer Situation |
|---------|---|---|-------------|--|
| 112-AN | TRANSACTION RESPONSE STATUS | R = Reject | M | |
| 5Ø3-F3 | AUTHORIZATION NUMBER | 13 character Internal Control Number (ICN) | 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, Appendix A – Reject Codes | 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 Rejected/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. 8ØØ5771278opt2 | 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 4: NCPDP Version D.0 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.0.

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 (110-AK) is Not used | X | |

| Field # | Transaction Header Segment | Value | Payer Usage | Claim Reversal Payer Situation |
|---------|----------------------------|--|-------------|-----------------------------------|
| 101-A1 | BIN NUMBER | 610467 | M | |
| 102-A2 | VERSION/RELEASE NUMBER | D0 | M | |
| 103-A3 | TRANSACTION CODE | B2 | M | |
| 104-A4 | PROCESSOR CONTROL NUMBER | INCAIDPROD = production INCAIDTEST = test | M | |

| Transaction Header Segment | | | Claim Reversal | |
|----------------------------|----------------------------------|--|----------------|-----------------|
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| 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 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 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: September 29, 2011 | |
| Plan Name/Group Name: Fee-For-Service/INCAID100 | BIN: 610467 | PCN: INCAIDPROD = production INCAIDTEST = test |

The following lists the segments and fields in a Claim Reversal response (Approved) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

| 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 |
| 102-A2 | VERSION/RELEASE NUMBER | D0 | M | |
| 103-A3 | TRANSACTION CODE | B2 | M | |
| 109-A9 | TRANSACTION COUNT | Same value as in request | M | |
| 501-F1 | HEADER RESPONSE STATUS | A = Accepted | M | |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | Same value as in request | M | |
| 201-B1 | SERVICE PROVIDER ID | Same value as in request | M | |
| 401-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 | |
| 503-F3 | AUTHORIZATION NUMBER | 13 character Internal Control Number (ICN) | RW | Required if needed to identify the transaction. |
| 130-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 number assigned by the provider for the dispensed drug/product and/or service provided 12 digit numeric | 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 | |

| | Response Transaction Header Segment | | | Claim Reversal – Accepted/Rejected |
|---------|-------------------------------------|--------------------------|-------------|------------------------------------|
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| 109-A9 | TRANSACTION COUNT | Same value as in request | M | |
| 501-F1 | HEADER RESPONSE STATUS | A = Accepted | M | |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | Same value as in request | M | |
| 201-B1 | SERVICE PROVIDER ID | Same value as in request | M | |
| 401-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 | |
| 503-F3 | AUTHORIZATION NUMBER | 13 character Internal Control Number (ICN) | R | |
| 510-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, Appendix A – Reject Codes | 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. |
| 130-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 Reversal – Accepted/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. 8ØØ5771278opt2 | 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 number assigned by the provider for the dispensed drug/product and/or service provided 12 digit numeric | 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 | |

| | Response Transaction Header Segment | | | Claim Reversal – Rejected/Rejected |
|---------|-------------------------------------|--------------------------|-------------|------------------------------------|
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| 201-B1 | SERVICE PROVIDER ID | Same value as in request | M | |
| 401-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 | |
| 503-F3 | AUTHORIZATION NUMBER | 13 character Internal Control Number (ICN) | R | |
| 510-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, Appendix A – Reject Codes | 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. |
| 130-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. 01 = first line 02 = second line 03 = third line 04 = fourth line 05 = fifth line 06 = sixth line 07 = seventh line 08 = eighth line 09 = ninth line | RW | Required if Additional Message Information (526-FQ) is used. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | Free text message. Maximum 40 bytes | RW | Required when additional text is needed for clarification or detail. |

| Response Status Segment Segment Identification (111-AM) = "21" | | | Claim Reversal – Rejected/Rejected | |
|---|----------------------------------|--|------------------------------------|---|
| Field # | NCPDP Field Name | Value | Payer Usage | Payer Situation |
| 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. 8ØØ5771278opt2 | 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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