ABARCA

NCPDP Transmission Specifications

Payer Sheet – Medicaid

General Information

Payer Name: AmeriHealth Caritas North Carolina	Release Date: 7/1/2021
Processor: Abarca Health	Standard: NCPDP D.Ø
Switches: Emdeon & RelayHealth	
PerformRx Customer Services / Providers Department: 1-866-885-1406	
AmeriHealth Caritas North Carolina Provider Services: 1-886-885-1406	
PerformRx Provider Relations Help Desk (Contracting Issues Only): 1-886-885-1406	
PerformRx Provider Relations Contact: pharmacynetworkcontracting@performrx.com	
Providers Portal: https://**prx**.darwinrx.com/providers	
Abarca Technical Issues (POS, Provider Portal Connectivity Issues Only): 1-866-286-6765	

Supported Transmissions

B1	Claim Billing
B2	Claim Reversal

This document contains important information for pharmacy claim submission at the point of sale for Medicaid plans.

The following specifications are based on the NCPDP D.Ø standard and are intended to explain how Abarca Health's processor handles supported transmissions. This document supplements, but does not contradict nor supersede, the official NCPDP Telecommunication Standard Version D.Ø implementation guide.

Users of this document should consult the NCPDP related documents listed below for further information and/or clarification:

NCPDP Telecommunication Implementation Guide Version D.Ø
Data Dictionary Full reference to all fields and values used in the NCPDP standard with examples.
External Code List Full reference to values used in the NCPDP standard.

Segment & Field Designation

This document lists segments and fields necessary for the proper composition of a transmission (see Supported Transmissions.) Depending on their designation, the sender should always (or conditionally) include some of them. This document uses the following designations:

M	Mandatory Fields required in accordance with the NCPDP Telecommunication Implementation Guide Version D.Ø.
R	Required Fields defined as situational by the NCPDP Telecommunication Implementation Guide Version D.Ø but required by Abarca Health's processor.
RW	Required When Conditional fields that are required based on a specific transmission scenario. Make sure to check the Comments and Value columns to understand when and how these fields should be included.
O	Optional Field may or may not be sent.
R	Repetition One or more values can be specified.

Optional fields defined by the NCPDP Telecommunication Implementation Guide Version D.Ø not included in this document can still be sent, but will not be observed by the processor's business logic. However, they must contain values that conform to the NCPDP standard.

These transmissions are used by the service provider to request payment from the processor for a specific patient for claims billed according to appropriate plan parameters.

Only one transaction per transmission is permitted.

Transaction Header Segment Mandatory

Field ID	Name	Designation	Value(s)	Comments
1Ø1-A1	Bin Number	M	019595	
1Ø2-A2	Version Release Number	M	DØ	
1Ø3-A3	Transaction Code	M	B1	B1 = Billing
1Ø4-A4	Processor Control Number	M	PRX00801	
1Ø9-A9	Transaction Count	M	1	A maximum of 1 (one) transaction per transmission is allowed.
2Ø2-B2	Service Provider ID Qualifier	M	Ø1	Ø1 = NPI Only NPI will be accepted
2Ø1-B1	Service Provider ID	M		National Provider ID (NPI)
4Ø1-D1	Date of Service	M		CCYYMMDD format
11Ø-AK	Software Vendor / Certification ID	M		Blanks are accepted

Insurance Segment Mandatory

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	Ø4	Insurance segment
3Ø2-C2	Cardholder ID	M		Use value as printed on the beneficiary's ID Card.
3Ø1-C1	Group ID	O		

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	Ø1	Patient segment
3Ø4-C4	Date of Birth	R		CCYYMMDD format
3Ø5-C5	Patient Gender Code	O	1 or 2	1 = Male 2 = Female
31Ø-CA	Patient First Name	O		
311-CB	Patient Last Name	O		
384-4X	Patient Residence	RW	2 = Skilled Nursing Facility = A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative service but does not provide the level of care or treatment available in a hospital 9 = Intermediate Care Facility/Mentally Retarded = A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF	

			11 = Hospice = A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided	

Claim Segment Mandatory

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	Ø7	Claim segment
455-EM	Prescription / Service Reference Number Qualifier	M	Ø1	Ø1 = Rx Billing Blank value will be treated as Ø1 (Rx Billing). *Imp Guide:* 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	M		
436-E1	Product / Service ID Qualifier	M	Ø3	Ø3 = NDC Only NDC will be accepted 00 = Multi-Ingredient Compound billing
4Ø7-D7	Product / Service ID	M		National Drug Code (NDC). Use Ø (zero) for multi-ingredient (compound) prescriptions. Format = MMMMMDDDDPP
456-EN	Associated Prescription / Service Reference Number	RW		Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. Required if transaction is the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)).

457-EP	Associated Prescription / Service Date	RW		Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. Required if transaction is the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)).
460-ET	Quantity Prescribed	RW		Used to identify incremental fills for Schedule II drug claims, as required under CMS-0055-F Quantity Prescribed Final Rule
442-E7	Quantity Dispensed	R		
4Ø3-D3	Fill Number	R	Ø to 99	Ø = Original 1 to 99 = Refill number
4Ø5-D5	Days Supply	R		
4Ø6-D6	Compound Code	R	1 or 2	1 = Not Compound 2 = Compound Ø is not an acceptable value and will be rejected.
4Ø8-D8	Dispense as Written (DAW) / Product Selection Code	R	Ø to 9	Refer to External Code List for value definitions.
414-DE	Date Prescription Written	R		CCYYMMDD format
415-DF	Number of Refills Authorized	O	Ø to 99	
419-DJ	Prescription Origin Code	RW	1 to 5	Imp Guide: Required if necessary for plan benefit administration. *Payer Requirement:* Required on original Rx. When Fill Number is '0' (Original Prescription), the POC requires a value of 1 – 5. Optional on refill Rx. When Fill Number is 1 – 99 (Refill Prescription), the POC may be submitted with value of 1 – 5. Note: POC editing for Original Rx varies by customer. If claim denies, will

				return NCPDP Reject Code '33' (M/I Prescription Origin Code).
354-NX	Submission Clarification Code Count	RW	Maximum count of 3	Required if Submission Clarification Code (42Ø-DK) is used.
42Ø-DK	Submission Clarification Code	RW		Required if clarification is needed and value submitted is greater than zero (Ø). 03 (Vacation Supply) must be populated on the claim in NCPDP Field #420 04 (lost prescription) must be populated on the claim in NCPDP field #420 05 (therapy change) 08 (process compound for approved ingredients) will allow non-formulary ingredients in a compound claim to pay if at least one of the ingredients in the compound is formulary. The pharmacy processing the claim will accepts the cost of the non-formulary ingredients in the compound (reimbursement is $0.00). If the Date of Service (4Ø1-D1) contains the subsequent payer coverage date, the Submission Clarification Code (42Ø-DK) is required with value of "19" (Split Billing – indicates the quantity dispensed is the remainder billed to a subsequent payer when Medicare Part A expires. Used only in long-term care settings) for individual unit of use medications.
3Ø8-C8	Other Coverage Code	RW	00= Not Specified 01—No other coverage identified 02=Other coverage exists-payment collected 03= other coverage exists-this claim not covered	Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers. Required for Coordination of Benefits. Allow OCC 0,1,2,3, and 4.

			4= other coverage exists- payment not collected	
418-DI	Level of Service	RW		Required for specific overrides or when requested by processor
461-EU	Prior Authorization Type Code	RW	1	1 = Prior Authorization Required when Prior Authorization Number Submitted (462-EV) is used.
462-EV	Prior Authorization Number Submitted	RW		Prior Authorization (PA) code provided by the processor when a claim has been rejected and can be overridden without clinical intervention. When a PA code is available, it will be sent in the rejected claim's Response Status Segment via Additional Message Information (526-FQ).
343-HD	Dispensing Status	RW	P, C	Required for the partial fill or the completion fill of a prescription.
344-HF	Quantity Intended To Be Dispensed	RW		Required for the partial fill or the completion fill of a prescription.
345-HG	Days Supply Intended To Be Dispensed	RW		Required for the partial fill or the completion fill of a prescription.
147-U7	Pharmacy Service Type	O		

Pricing Segment Mandatory

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	11	Pricing segment
4Ø9-D9	Ingredient Cost Submitted	R		
412-DC	Dispensing Fee Submitted	RW		
433-DX	Patient Paid Amount Submitted	RW		
478-H7	Other Amount Claimed Submitted Count	RW		
479-H8	Other Amount Claimed Submitted Qualifier	RW		

480-H9	Other Amount Claimed Submitted	RW		
438-E3	Incentive Amount Submitted	RW		Imp Guide: Required if its value has an effect on the Gross Amount Due (430—DU) calculation. Payer requirement: Same as Imp Guide. Vaccine Administration: If field is submitted, then field 440-E5 (Professional Service Code) must be submitted with value of MA or claim will reject.
426-DQ	Usual And Customary Charge	RW		Required when there's a trading partner agreement.
43Ø-DU	Gross Amount Due	R		
481-HA	Flat Sales Tax Amount Submitted	RW		Required when flat sales tax is applicable to the product dispensed.
482-GE	Percentage Sales Tax Amount Submitted	RW		Required when submitting Percentage Sales Tax Rate Submitted (483-HE) and Percentage Sales Tax Basis Submitted (484-JE).
483-HE	Percentage Sales Tax Rate Submitted	RW		Required when submitting Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE). Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).
484-JE	Percentage Sales Tax Basis Submitted	RW		Required when submitting Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE). Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).
423-DN	Basis of Cost Determination	RW		

Prescriber Segment Required

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	Ø3	Prescriber segment
466-EZ	Prescriber ID Qualifier	R	Ø1	Imp Guide: Required if Prescriber ID (411-DB) is used. Ø1 = National Provider ID (NPI)
411-DB	Prescriber ID	R		Imp Guide: Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. Payer Requirement: Prescriber NPI required. If claim rejects for NCPDP reject code 25 (M/I Prescriber ID), contact our Pharmacy Contact Center for further information
367-2N	Prescriber State / Province Address	O		

COB / Other Payments Segment Optional

Used only when transmission is sent to a secondary, tertiary, etc. payer. Never send to primary payer. Only 1 (one) transaction per transmission is permitted when this segment is used. Vaccine administration transmissions cannot be sent with this segment. COB Scenario 1 must be used.

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 1 – Other Payer Amount Paid Repetitions Only	X	
Scenario 2 – Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
Scenario 3 – Other Payer Amount Paid, Other Payer Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		

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Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	Ø5	COB / Other Payments segment

337-4C	COB / Other Payments Count	M	1 to 9	Maximum count of 9
338-5C	Other Payer Coverage Type	M	Ø1 to Ø9	Refer to External Code List for value definitions.
339-6C	Other Payer ID Qualifier	RW	Ø1, Ø2, Ø3, Ø4, Ø5, 99	Required if Other Payer ID (34Ø-7C) is used.
34Ø-7C	Other Payer ID	RW		Required if identification of the Other Payer is necessary for claim/encounter adjudication.
443-E8	Other Payer Date	RW		CCYYMMDD format. Required if Other Payer ID (34Ø-7C) is used.
341-HB	Other Payer Amount Paid Count	RW		Required if Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	Other Payer Amount Paid Qualifier	RW		Required if Other Payer Amount Paid (431-DV) is used.
353-NR	Other Payer-Patient Responsibility Amount Count	O	1 to 25	
431-DV	Other Payer Amount Paid	RW		Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted.
351-NP	Other Payer-Patient Responsibility Amount Qualifier	O	Ø1, Ø2, Ø3, Ø4, Ø5, Ø6, Ø7, Ø8, Ø9, 1Ø, 11, 12, 13	
352-NQ	Other Payer-Patient Responsibility Amount	O		
471-5E	Other Payer Reject Count	RW	1 to 5	Maximum count of 5. Required when Other Payer Reject Code (472-6E) is used.
472-6E	Other Payer Reject Code	RW		Must only contain valid NCPDP Reject Codes. 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).

Compound Segment Required When

Segment required only when a Compound transmission is sent. Include segment when Compound Code (4Ø6-D6 from Claim segment) is sent with value of 2 (two).

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	1Ø	Compound segment
45Ø-EF	Compound Dosage Form Description Code	M	Ø1, Ø2, Ø3, Ø4, Ø5, Ø6, Ø7, 1Ø, 11, 12, 13, 14, 15, 16, 17, 18	Refer to External Code List for value definitions. Blank is accepted.
451-EG	Compound Dispensing Unit Form Indicator	M	1 to 3	1 = Each 2 = Grams 3 = Milliliters
447-EC	Compound Ingredient Component Count	M	2 to 25	Minimum of 2 and a maximum of 25 ingredients per transmission.
488-RE	Compound Product ID Qualifier	M**R**	Ø3	Ø3 = National Drug Code (NDC)
489-TE	Compound Product ID	M**R**		National Drug Code (NDC).
448-ED	Compound Ingredient Quantity	M**R**		
449-EE	Compound Ingredient Drug Cost	RW		Required if needed for receiver claim determination when multiple products are billed.
490-UE	Compound Ingredient Basis of Cost Determination	RW		Required if needed for receiver claim determination when multiple products are billed.

Clinical Segment Required When

Segment required when requested to submit clinical information that will affect the outcome of claims processing.

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	RW	13	Clinical Segment

491-VE	Diagnosis Code Count	RW	Maximum Count 5	Imp Guide: Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. Payer Requirement: (Same as Imp Guide).
492-WE	Diagnosis Code Qualifier	RW		Imp Guide: Required if Diagnosis Code (424- DO) is used. Payer Requirement: (Same as Imp Guide).
424-DO	Diagnosis Code	RW		Imp Guide: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs. Payer Requirement: Required when submitting Injectable or Neurontin

DUR/PPS Segment Required When

Segment required when DUR/PPS codes are submitted.

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	RW	08	DUR/PPS Segment
473-7E	DUR/PPS Code Counter	RW	Maximum Count 9	*Imp Guide:* Required if DUR/PPS Segment is used. *Payer Requirement: Same as Imp Guide*
439-E4	Reason for Service Code	RW		*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.

				Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* Same as Imp Guide.
440-E5	Professional Service Code	RW		*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* Same as Imp Guide.
441-E6	Result of Service Code	RW		*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* Same as Imp Guide.

Claim Reversal Transmissions

The reversal transmission is used to "back out" a previously paid prescription. Only one reversal transaction per transmission are permitted. However, a transmission containing multiple reversals for multiple patients will not be allowed.

Matching for a claim to be reversed is done by: Processor Control Number, Service Provider ID, Date of Service, Cardholder ID, Prescription / Service Reference Number, Product / Service ID, and Fill Number (all inclusive). Failing to provide all these details with precision will cause a rejection in most cases.

All reversals are final and cannot be un-done. We strongly advise to double check all reversals before submission to avoid any unintended consequences.

Transaction Header Segment Mandatory

Field ID	Name	Designation	Value(s)	Comments
1Ø1-A1	Bin Number	M	019595	

1Ø2-A2	Version Release Number	M	DØ	
1Ø3-A3	Transaction Code	M	B2	B2 = Reversal
1Ø4-A4	Processor Control Number	M	PRX00801	
1Ø9-A9	Transaction Count	M	1	
2Ø2-B2	Service Provider ID Qualifier	M	Ø1	Ø1 = NPI Only NPI will be accepted
2Ø1-B1	Service Provider ID	M		National Provider ID (NPI)
4Ø1-D1	Date of Service	M		CCYYMMDD format
11Ø-AK	Software Vendor / Certification ID	M		Blanks are accepted

Insurance Segment Mandatory

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	Ø4	Insurance segment
3Ø2-C2	Cardholder ID	M		Use value as printed on the beneficiary's ID Card
3Ø1-C1	Group ID	O		

Claim Segment Mandatory

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	Ø7	Claim segment
455-EM	Prescription / Service Reference Number Qualifier	M	1	1 = Rx Billing Blank value will be defaulted to 1 (Rx Billing)
4Ø2-D2	Prescription / Service Reference Number	M		
436-E1	Product / Service ID Qualifier	M	Ø3	Ø3 = NDC Only NDC will be accepted
4Ø7-D7	Product / Service ID	M		National Drug Code (NDC). Use Ø (zero) for multi-ingredient (compound) prescriptions.
4Ø3-D3	Fill Number	R	Ø to 11	Ø = Original

				1 to 11 = Refill number

Response Transmission

Response Header Segment Mandatory

Field ID	Name	Designation	Value(s)	Comments
1Ø2-A2	Version Release Number	M	DØ	
1Ø3-A3	Transaction Code	M	B1, B2	B1 = Billing B2 = Reversal
1Ø9-A9	Transaction Count	M	1	The amount of response transactions will match the amount of request transactions sent in the billing or reversal transmission.
5Ø1-F1	Header Response Status	M	A, D, R	A = Accepted D = Duplicate of Paid R = Rejected
2Ø2-B2	Service Provider ID Qualifier	M	Ø1	Ø1 = NPI
2Ø1-B1	Service Provider ID	M		National Provider ID (NPI) to which the response is being sent.
4Ø1-D1	Date of Service	M		CCYYMMDD format

Response Message Segment Optional

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	2Ø	Response Message segment
5Ø4-F4	Message	O		Transmission level clarification details if needed. In most cases the patient name will be sent.

Response Insurance Segment Optional

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	25	Response Insurance segment
524-FO	Plan ID	O		

Response Status Segment

Mandatory

A response status segment will be included for each transaction contained in the request transmission.

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	21	Response Status segment
112-AN	Transaction Response Status	M	P, A, D, R	P = Paid A = Approved D = Duplicate of Paid R = Rejected
5Ø3-F3	Authorization Number	RW		Internal Claim Number (ICN). Only sent when a billing or reversal record was generated in the processor's claim system.
51Ø-FA	Reject Count	RW		Maximum count of 5. Required when Reject Code (511-FB) is used.
511-FB	Reject Code	RW		Required when Transaction Response Status (112-AN) is R (Rejected).
547-5F	Approved Message Code Count	RW		Required when Approved Message Code (548-6F) is used.
548-6F	Approved Message Code	RW	ØØ1, ØØ2, ØØ3, ØØ4, ØØ5, ØØ6, Ø19, Ø21	Refer to External Code List for value definitions. Optionally sent when Transaction Response Status (112-AN) is P (Paid).
13Ø-UF	Additional Message Information Count	RW	1 to 25	Maximum count of 25. Required when Additional Message Information (526-FQ) is used.
132-UH	Additional Message Information Qualifier	RW **R**	Ø1 to Ø9	Refer to External Code List for value definitions. Required when Additional Message Information (526-FQ) is used.
526-FQ	Additional Message Information	RW **R**		Required when additional text is needed for clarification or detail.
131-UG	Additional Message Information Continuity	RW **R**	+ (plus sign)	Required when current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message

				Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	Help Desk Phone Number Qualifier	RW	Ø3	Ø3 = Processor / PBM Required when Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	Help Desk Phone Number	RW		Only sent when the Transaction Response Status (112-AN) is R (Rejected).

Response Claim Segment Required When

Required when the Transaction Response Status (112-AN) is A (accepted), P (paid) or D (duplicate of paid).

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	22	Response Claim segment
455-EM	Prescription / Service Reference Number Qualifier	M	1	1 = Rx Billing
4Ø2-D2	Prescription / Service Reference Number	M		Same value sent in the original billing or reversal transaction.
551-9F	Preferred Product Count	RW	1 to 6	Maximum count of 6. Required when Preferred Product ID (553-AR) is used.
552-AP	Preferred Product ID Qualifier	RW **R**	Ø3	Ø3 = National Drug Code (NDC). Required when Preferred Product ID (553-AR) is used.
553-AR	Preferred Product ID	O**R**		National Drug Code (NDC)
554-AS	Preferred Product Incentive	O**R**		
555-AT	Preferred Product Cost Share Incentive	O**R**		
556-AU	Preferred Product Description	O**R**		

Response Pricing Segment Required When

Required when the Transaction Response Status (112-AN) is A (accepted), P (paid) or D (duplicate of paid). Not included in reversal responses.

Field ID	Name	Designation	Value(s)	Comments

111-AM	Segment Identification	M	23	Response Pricing segment
5Ø5-F5	Patient Pay Amount	R		Amount the patient is expected to pay (out of pocket).
5Ø6-F6	Ingredient Cost Paid	R		
5Ø7-F7	Dispensing Fee Paid	R		In the case of vaccine administrations, if there is a vaccine flat price contracted with the service provider, the field will contain Ø (zero).
557-AV	Tax Exempt Indicator	O	1	1 = Payer / Plan is tax exempt
558-AW	Flat Sales Tax Amount Paid	RW		Required when Flat Sales Tax Amount Submitted (481-HA) is greater than Ø (zero) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement. Otherwise Ø (zero) will be sent.
559-ZX	Percentage Sales Tax Amount Paid	RW		Required when Percentage Sales Tax Amount Submitted (482-GE) is greater than Ø (zero). Otherwise Ø (zero) will be sent.
56Ø-AY	Percentage Sales Tax Rate Paid	RW		Required when Percentage Sales Tax Amount Paid (559-AX) is greater than Ø (zero).
561-AZ	Percentage Sales Tax Rate Paid	RW	Ø2, Ø3	Ø2 = Ingredient Cost Ø3 = Ingredient Cost + Dispensing Fee Required when Percentage Sales Tax Amount Paid (559-AX) is greater than Ø (zero).
521-FL	Incentive Amount Paid	RW		Required when a vaccine administration claim is processed. It contains the administration fee. If there is a vaccine flat price contracted with the service provider, the field will contain Ø (zero).
563-J2	Other Amount Paid Count	RW	Maximum count of 3	Imp Guide: Required if Other Amount Paid (565-J4) is used.
564-J3	Other Amount Paid Qualifier	RW		Imp Guide: Required if Other Amount Paid (565-J4) is used
565-J4	Other Amount Paid	RW		Imp Guide: Required if this value is used to arrive at the final reimbursement.

				Required if Other Amount Claimed Submitted (48Ø-H9) is greater than zero (Ø)
566-J5	Other Payer Amount Recognized	RW		Required when the billing claim had Coordination of Benefits (COB) amounts.
5Ø9-F9	Total Amount Paid	R		Amount covered by the plan.
522-FM	Basis of Reimbursement Determination	RW	Ø to 21	Required when Ingredient Cost Paid (5Ø6-F6) is greater than Ø (zero). Refer to External Code List for value definitions.
517-FH	Amount Applied to Periodic Deductible	RW		Required when the Patient Pay Amount (5Ø5-F5) includes deductible.
518-FI	Amount of Copay	RW		Required when the Patient Pay Amount (5Ø5-F5) includes copay as patient financial responsibility. Payer Requirement: Member Copayments= $0.00
52Ø-FK	Amount Exceeding Periodic Benefit Maximum	RW		Required when the Patient Pay Amount (5Ø5-F5) includes amount exceeding periodic benefit maximum.
575-EQ	Patient Sales Tax Amount	O		Used when necessary to identify the Patient's portion of the Sales Tax.
574-2Y	Plan Sales Tax Amount	O		Used when necessary to identify the Plan's portion of the Sales Tax.
572-4U	Amount of Coinsurance	RW		Required if Patient Pay Amount (5Ø5-F5) includes coinsurance as patient financial responsibility.
134-UK	Amount Attributed to Product Selection / Brand Drug	RW		Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand drug.
136-UN	Amount Attributed to Product Selection / Brand Non-Preferred Formulary Selection	RW		Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand drug.
148-U8	Ingredient Cost Contracted / Reimbursable Amount	RW		Required when Basis of Reimbursement Determination (522-

				FM) is “14” (Patient Responsibility Amount) or “15” (Patient Pay Amount).
149-U9	Dispensing Fee Contracted / Reimbursable Amount	RW		Required when Basis of Reimbursement Determination (522-FM) is “14” (Patient Responsibility Amount) or “15” (Patient Pay Amount).

Response DUR / PPS Segment Optional

Optionally used when the Transaction Response Status (112-AN) is A (accepted), P (paid) or D (duplicate of paid). Not included in reversal responses.

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	24	Response DUR / PPS segment
567-J6	DUR / PPS Response Code Counter	RW **R**	1 to 9	Maximum counter of 9. Required when segment is used.
439-E4	Reason for Service Code	RW **R**	Refer to External Code List for all possible values.	Required when utilization conflict is detected.
528-FS	Clinical Significance Code	RW **R**	1, 2, 3, 9	1 = Major 2 = Moderate 3 = Minor 9 = Undetermined Required when needed to supply additional information for the utilization conflict.
53Ø-FU	Previous Date Filled	RW **R**		CCYYMMDD format. Required when needed to supply additional information for the utilization conflict.
531-FV	Quantity of Previous Fill	RW **R**		Required when needed to supply additional information for the utilization conflict.
532-FW	Database Indicator	R**R**	2	2 = Medi-Span
544-FY	DUR Free Text Message	RW **R**		Required when needed to supply additional information for the utilization conflict.

Response COB / Other Payer Segment Optional

Optionally used when the Transaction Response Status (112-AN) is A (accepted), P (paid) or D (duplicate of paid). Not included in reversal responses.

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	28	Response DUR / PPS segment
355-NT	Other Payer ID Count	M	1 to 3	Maximum count of 3.
338-5C	Other Payer Coverage Type	M**R**	Blank, Ø1 to Ø9	Refer to External Code List for value definitions.
339-6C	Other Payer ID Qualifier	RW **R**	Ø3	Ø3 = Bank Information Number (BIN) Required when Other Payer ID (34Ø-7C) is used.
34Ø-7C	Other Payer ID	RW **R**		Bank Information Number (BIN). Required when the other payer has BIN.
991-MH	Other Payer Processor Control Number	O**R**		
356-NU	Other Payer Cardholder ID	O**R**		
992-MJ	Other Payer Group ID	O**R**		
142-UV	Other Payer Person Code	O**R**		
144-UX	Other Payer Benefit Effective Date	O**R**		CCYYMMDD format.
145-UY	Other Payer Benefit Termination Date	O**R**		CCYYMMDD format.

Document Change Log

Release Date	Notable Changes
9/28/2020	Inserted New Field 460-ET – Quantity Prescribed
06/09/2021	Added fields 563-J2 - Other Amount Paid Count, 564-J3 - Other Amount Paid Qualifier and 565-J4- Other Amount Paid to Response Pricing Segment. Added field 418-DI – Level of Service to Claim Segment.