ABARCA

NCPDP Transmission Specifications

Payer Sheet – Medicare

General Information

Payer Name: Amerihealth Caritas VIP Next, Inc	Release Date: 01/01/2023
Processor: Abarca Health	Standard: NCPDP D.Ø
Switches: Emdeon & RelayHealth	
PerformRx Customer Services / Providers Department: 1-855-327-0510	
AmeriHealth Caritas VIP Next, Inc Provider Services: 1-833-376-7790	
PerformRx Provider Relations Help Desk (Contracting Issues Only): 1-800-555-5690	
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

Overview

This document contains important information for pharmacy claim submission at the point of sale for Medicare 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	019587	
1Ø2-A2	Version Release Number	M	DØ	
1Ø3-A3	Transaction Code	M	B1	B1 = Billing
1Ø4-A4	Processor Control Number	M	PRX01815	
1Ø9-A9	Transaction Count	M	1	A maximum of 1 (one) transaction 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		
997-G2	CMS Part D Defined Qualified Facility	RW	Y or N	Y = Yes (CMS qualified) N = No (Not CMS qualified) Required when the patient resides and/or receives services from a Long Term Care (LTC) facility.

Patient Segment — Mandatory

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
3Ø7-C7	Place of Service	RW		Refer to External Code List for values and definitions. Required when the patient resides and/or receives services from a Long Term Care (LTC) facility.
31Ø-CA	Patient First Name	O		
311-CB	Patient Last Name	O		
384-4X	Patient Residence	RW	1-Home 3-Nursing Facility 4-Assisted Living Facility 6-Group Home 9- Intermediate Care Facility /Mentally Retarded 11-Hospice	Blank value will be treated as 1-Home.

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	00 or Ø3	Ø3 = NDC 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	RW	Ø to 99	0 = No Refills Authorized 1-99 = Authorized Refill Number – 99 being as needed refills
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 '00' (Original Prescription), the POC requires a value of 1 – 5. Optional on refill Rx. When Fill Number is 01 – 99 (Refill Prescription), the POC may be submitted with values of 1 – 5. 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile 5 = Pharmacy
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). SCC usage is based upon NCPDP guidance. Initial compound claims may be submitted without SCC 8 to determine which drugs will be covered, but claims with non-covered ingredients must then be resubmitted with SCC 8. Some LTC scenarios require SCC codes to process – SCC values 7, 13-17, 21-36 will be accepted An applicable LTC Oral Solid Brand Dispensing claim must have Pharmacy Service Type 05 and Patient Residence equal to 03 or 09, along with the appropriate Submission Clarification Code and Special Package Indicator value combinations for oral solid brand drugs.
3Ø8-C8	Other Coverage Code	RW	00= Not Specified 01—No other coverage identified 02=Other coverage exists-payment collected 03= other coverage exists-	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

			this claim not covered 4= other coverage exists- payment not collected	
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	R	1 to 8, 99	Imp Guide: Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer.
429-DT	Special Packaging Indicator	RW	0 to 9	To be used in conjunction with 147-U7 – Pharmacy Service Type, 384-DX- Patient Residence, and 420-DK – Submission Clarification Code for Medicare Part D Long Term Care (LTC) Appropriate Dispensing An applicable LTC Appropriate Dispensing claim must have Pharmacy Service Type 05 and Patient Residence equal to 03 or 09, along with the appropriate Submission Clarification Code and Special Package Indicator value combinations for oral solid brand drugs.

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		Imp Guide: Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
433-DX	Patient Paid Amount Submitted	RW		Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility.
478-H7	Other Amount Claimed Submitted Count	RW	Maximum count of 3	Imp Guide: Required if Other Amount Claimed Submitted Qualifier (479-H8) is used
479-H8	Other Amount Claimed Submitted Qualifier	RW		Imp Guide: Required if Other Amount Claimed Submitted (48Ø-H9) is used
480-H9	Other Amount Claimed Submitted	RW		Imp Guide: Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
438-E3	Incentive Amount Submitted	O		
426-DQ	Usual And Customary Charge	RW		Required when there's a trading partner agreement.
43Ø-DU	Gross Amount Due	R		Imp Guide: GAD Required. Necessary for plan benefit administration.
481-HA	Flat Sales Tax Amount Submitted	RW		Imp Guide: Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
482-GE	Percentage Sales Tax Amount Submitted	RW		Imp Guide: Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. 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		Imp Guide: Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).

484-JE	Percentage Sales Tax Basis Submitted	RW		Imp Guide: Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).

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.

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	Ø5	COB / Other Payments segment
337-4C	COB / Other Payments Count	M	Maximum count of 9	
338-5C	Other Payer Coverage Type	M		

339-6C	Other Payer ID Qualifier	RW		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	RW	Maximum count of 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	RW		
352-NQ	Other Payer-Patient Responsibility Amount	RW		
471-5E	Other Payer Reject Count	RW	Maximum count of 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).

DUR/PPS Segment — Required When

Segment required only when additional information is needed (112-AN) is A (accepted), P (paid) or D (duplicate of paid).

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 of 9	*Imp Guide:* Required if DUR/PPS Segment is used.
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. NP = New Patient Processing Required when a Submission Clarification Code (42Ø-DK) for LTC rejection override is sent.
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. ØØ = No Intervention (for LTC rejection overrides) MA = Medication Administration (for vaccine administrations)
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.

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		

451-EG	Compound Dispensing Unit Form Indicator	M		1 = Each 2 = Grams 3 = Milliliters
447-EC	Compound Ingredient Component Count	M		Minimum of 2 and a maximum of 25 ingredients per transmission.
488-RE	Compound Product ID Qualifier	M**R**		Ø3 = National Drug Code (NDC)
489-TE	Compound Product ID	M**R**		
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 only when additional information is needed (112-AN) is A (accepted), P (paid) or D (duplicate of paid).

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	RW	13	Clinical Segment
491-VE	Diagnosis Code Count	RW	Maximum count of 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.

Claim Reversal Transmissions

The reversal transmission is used to "back out" a previously paid prescription. Only one reversal transaction per transmission is 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	019587	
1Ø2-A2	Version Release Number	M	DØ	
1Ø3-A3	Transaction Code	M	B2	B2 = Reversal
1Ø4-A4	Processor Control Number	M	PRX01815	
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		
545-2F	Network Reimbursement ID	RW		Imp Guide: Required if needed to identify the network for the covered member. Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available. Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist

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	00 or Ø3	Ø3 = NDC 00 = Multi-Ingredient Compound billing
4Ø7-D7	Product / Service ID	M		0 = If Compound, otherwise 11 digit NDC
4Ø3-D3	Fill Number	R	Ø to 99	Ø = Original dispensing - The first dispensing 1-99 = Refill number - Number of the replenishment

Response Transmission

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

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	Maximum count of 4	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	2Ø	Response Message 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	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	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	RW		Imp Guide: Required if this value is used to arrive at the final reimbursement
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 Basis Paid	RW		Imp Guide: Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).
521-FL	Incentive Amount Paid	RW		Imp Guide: Required if this value is used to arrive at the final reimbursement. Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø).
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		Imp Guide: Required if this value is used to arrive at the final reimbursement. Required if Other Payer Amount Paid (431DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.
5Ø9-F9	Total Amount Paid	R		Amount covered by the plan.
522-FM	Basis of Reimbursement Determination	RW		Required when Ingredient Cost Paid (5Ø6-F6) is greater than Ø (zero). Refer to External Code List for value definitions. Required if Basis of Cost Determination (432-DN) is submitted on billing.
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.
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.
392-MU	Benefit Stage Count	RW	Maximum count of 4	Imp Guide: Required if Benefit Stage Amount (394-MW) is used.
393-MV	Benefit Stage Qualifier	RW		Imp Guide: Required if Benefit Stage Amount (394-MW) is used. Ø1 = Deductible Ø2 = Initial Benefit Ø3 = Coverage Gap Ø4 = Catastrophic Coverage
394-MW	Benefit Stage Amount	RW		Imp Guide: Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs
134-UK	Amount Attributed to Product Selection / Brand Drug	RW	Maximum count of 4	Imp Guide: Required if Benefit Stage Amount (394-MW) is used.
137-UP	Amount Attributed to Coverage Gap	RW		Required when the patient's financial responsibility is due to the coverage gap.

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**	Maximum count of 9	Required when segment is used.
439-E4	Reason for Service Code	RW **R**		Required when utilization conflict is detected. Refer to External Code List for all possible values.
528-FS	Clinical Significance Code	RW **R**		Required when needed to supply additional information for the utilization conflict. 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined

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	RW		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	Maximum count of 3	
338-5C	Other Payer Coverage Type	RW		
339-6C	Other Payer ID Qualifier	RW **R**		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. Imp Guide: Required if other insurance information is available for coordination of benefits.
991-MH	Other Payer Processor Control Number	RW		Imp Guide: Required if other insurance information is available for coordination of benefits.
356-NU	Other Payer Cardholder ID	RW		Imp Guide: Required if other insurance information is available for coordination of benefits.
992-MJ	Other Payer Group ID	RW		Imp Guide: Required if other insurance information is available for coordination of benefits.
142-UV	Other Payer Person Code	RW		Imp Guide: Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer.

144-UX	Other Payer Benefit Effective Date	RW		CCYYMMDD format.
145-UY	Other Payer Benefit Termination Date	RW		CCYYMMDD format.

Document Change Log

Release Date	Notable Changes
9/27/2022	Initial revision