

NCPDP Transmission Specifications

Payer Sheet – Medicaid

General Information

Payer Name: Geisinger Family Health Plan	Release Date: 01/01/2021
Processor: Abarca Health	Standard: NCPDP D.Ø
Switches: Emdeon & RelayHealth	
Geisinger Health Plan Customer Services / Providers Department: 1-855-552-6028	
Geisinger Health Plan Provider Services: 1-855-552-6028	
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.

Claim Billing Transmissions

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.

Transaction Header Segment

Mandatory

Field ID	Name	Designation	Value(s)	Comments
101-A1	Bin Number	M	019595	
102-A2	Version Release Number	M	D0	
103-A3	Transaction Code	M	B1	B1 = Billing
104-A4	Processor Control Number	M	PRX11804	
109-A9	Transaction Count	M	1	Up to 1 (one) transactions per transmission are permitted
202-B2	Service Provider ID Qualifier	M	01	01 = NPI Only NPI will be accepted
201-B1	Service Provider ID	M		National Provider ID (NPI)
401-D1	Date of Service	M		CCYYMMDD format
110-AK	Software Vendor / Certification ID	M		Blanks are accepted

Insurance Segment

Mandatory

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	04	Insurance segment
302-C2	Cardholder ID	M		Use value as printed on the beneficiary's ID Card. Must be 11 digits.
301-C1	Group ID	O		

Patient Segment

Mandatory

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	01	Patient segment
304-C4	Date of Birth	R		CCYYMMDD format
305-C5	Patient Gender Code	O	1 or 2	1 = Male

				2 = Female
307-C7	Place of Service	O		Refer to External Code List for values and definitions.
310-CA	Patient First Name	R		
311-CB	Patient Last Name	R		
384-4X	Patient Residence	R	0, 1, 3, 4, 6, 9, 11, or 15	0 – Not Specified 1 – Home 3 – Nursing Facility (Required when the patient resides and/or receives services from a Long Term Care (LTC) facility. May be used in combination with or in replace of Pharmacy Service Type 05.) 4 – Assisted Living Facility 6 – Group Home 9 – Intermediate Care Facility/Mentally Retarded 11 – Hospice 15 – Correctional Institution

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). <i>Imp Guide:</i> For Transaction Code of “B1”, in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing).
402-D2	Prescription / Service Reference Number	M		
436-E1	Product / Service ID Qualifier	M	Ø3	Ø3 = NDC Only NDC will be accepted
407-D7	Product / Service ID	M		National Drug Code (NDC). Use Ø (zero) for multi-ingredient (compound) prescriptions. Format = MMMMDDDDPP

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		
403-D3	Fill Number	R	Ø to 99	Ø = Original 1 to 99 = Refill number
405-D5	Days Supply	R		
406-D6	Compound Code	R	1 or 2	1 = Not Compound 2 = Compound
408-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	Imp Guide: Required if necessary for plan benefit administration. Payer Requirement: Same as Imp Guide
419-DJ	Prescription Origin Code	R	1 to 5	Imp Guide: Required if necessary for plan benefit administration. 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile 5 = Pharmacy

354-NX	Submission Clarification Code Count	RW	1 to 3	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 allowed: •SCC 03 – Vacation Supply •SCC 04 – Lost, Stolen, Spilled Supply •SCC 08 – overrides non-formulary/non-covered Compound Ingredients/Medicaid Non-Rebatable (pharmacy will absorb the cost)
3Ø8-C8	Other Coverage Code	RW	02=Other coverage exists- payment collected 03= other coverage exists- this claim not covered 4= other coverage exists- payment not collected	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 2,3, and 4
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, RW	1 to 8, 99	<p>Refer to External Code List for value definitions.</p> <p>Pharmacy Service Type 05 is required when the patient resides and/or receives services from a Long Term Care (LTC) facility. May be used in combination with or in replace of Patient Residence Code 03.</p> <p>Field is optional for all other processing.</p>
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Pricing Segment

Mandatory

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	11	Pricing segment
409-D9	Ingredient Cost Submitted	R		
412-DC	Dispensing Fee Submitted	RW		<p>Imp Guide: Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.</p> <p>Payer Requirement: Same as Imp Guide.</p>
433-DX	Patient Paid Amount Submitted	RW		<p>Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility.</p> <p>Payer Requirement: Same as Imp Guide.</p>
478-H7	Other Amount Claimed Submitted Count	RW		<p>Imp Guide: Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.</p> <p>Payer Requirement: (Same as Imp Guide).</p>
479-H8	Other Amount Claimed Submitted Qualifier	RW		<p>Imp Guide: Required if Other Amount Claimed Submitted (48Ø-H9) is used.</p> <p>Payer Requirement: (Same as Imp Guide).</p>
480-H9	Other Amount Claimed Submitted	RW		<p>Imp Guide: Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.</p> <p>Payer Requirement: (Same as Imp Guide).</p>
438-E3	Incentive Amount Submitted	RW		<p>Required when Vaccine Administration transmissions are sent. Contains the pharmacy administration fee amount. <i>Must also populate the Professional Service code (44Ø-E5 from DUR / PPS Segment) with 'MA'.</i></p>
426-DQ	Usual And Customary Charge	R		

43Ø-DU	Gross Amount Due	R		Imp Guide: GAD Required. Necessary for plan benefit administration.
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).
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).
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.

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	1 to 9	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.
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.
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).

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	1 to 9	<i>Imp Guide:</i> Required if DUR/PPS Segment is used. Maximum Count 9
439-E4	Reason for Service Code	RW		<i>Imp Guide:</i> 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.
440-E5	Professional Service Code	RW		<i>Imp Guide:</i> 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. MA = Medication Administration (for vaccine administrations)
441-E6	Result of Service Code	RW		<i>Imp Guide:</i> 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 (406-D6 from Claim segment) is sent with value of 2 (two).

Field ID	Name	Designation	Value(s)	Comments
111-AM	Segment Identification	M	10	Compound segment
450-EF	Compound Dosage Form Description Code	M	01, 02, 03, 04, 05, 06, 07, 10, 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 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 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. Up to 4 reversal transactions 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	019595	
1Ø2-A2	Version Release Number	M	DØ	
1Ø3-A3	Transaction Code	M	B2	B2 = Reversal
1Ø4-A4	Processor Control Number	M	PRX11804	
1Ø9-A9	Transaction Count	M	1	Up to 1 (one) transactions per transmission are permitted
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. Must be 11 digits.
3Ø1-C1	Group ID	O		

Patient Segment

Field ID	Name	Designation	Value(s)	Comments
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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.
31Ø-CA	Patient First Name	O		
311-CB	Patient Last Name	O		
384-4X	Patient Residence	R	0, 1, 3, 4, 6, 9, 11, or 15	0 – Not Specified 1 – Home 3 – Nursing Facility (Required when the patient resides and/or receives services from a Long Term Care (LTC) facility. May be used in combination with or in replace of Pharmacy Service Type 05.) 4 – Assisted Living Facility 6 – Group Home 9 – Intermediate Care Facility/Mentally Retarded 11 – Hospice 15 – Correctional Institution

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 99	Ø = Original 1 to 99 = Refill number

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.0.

Response Header Segment

Mandatory

Field ID	Name	Designation	Value(s)	Comments
102-A2	Version Release Number	M	DØ	
103-A3	Transaction Code	M	B1, B2	B1 = Billing B2 = Reversal
109-A9	Transaction Count	M	1	The amount of response transactions will match the amount of request transactions sent in the billing or reversal transmission.
501-F1	Header Response Status	M	A, D, R	A = Accepted D = Duplicate of Paid R = Rejected
202-B2	Service Provider ID Qualifier	M	Ø1	Ø1 = NPI
201-B1	Service Provider ID	M		National Provider ID (NPI) to which the response is being sent.
401-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
504-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
503-F3	Authorization Number	RW		Internal Claim Number (ICN). Only sent when a billing or reversal record was generated in the processor's claim system.
510-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	Ø01, Ø02, Ø03, Ø04, Ø05, Ø06, Ø19, Ø21	Refer to External Code List for value definitions. Optionally sent when Transaction Response Status (112-AN) is P (Paid).
130-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 (550-8F) is used.
550-8F	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
402-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
505-F5	Patient Pay Amount	R		Amount the patient is expected to pay (out of pocket).
506-F6	Ingredient Cost Paid	R		
507-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).
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 (505-F5) includes coinsurance as patient financial responsibility.
134-UK	Amount Attributed to Product Selection / Brand Drug	RW		Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a Brand drug.

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.
530-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, 01 to 09	Refer to External Code List for value definitions.
339-6C	Other Payer ID Qualifier	RW **R**	03	03 = Bank Information Number (BIN) Required when Other Payer ID (340-7C) is used.
340-7C	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.

