

## NCPDP Transmission Specifications

Payer Sheet – Medicare

### General Information

|  |                                 |
|--|---------------------------------|
| Payer Name: <b>AmeriHealth Caritas VIP Care North Carolina Medicare</b>  | Release Date: <b>01/01/2026</b> |
| BIN: <b>019587</b>   | PCN: <b>PRX01825</b>            |
| Processor: <b>Abarca Health</b>  | Standard: <b>NCPDP D.Ø</b>      |
| Switches: Emdeon & RelayHealth   |                                 |
| Customer Services / Providers Department: 1-866-773-7991   |                                 |
| Provider Services: 1-855-251-0962  |                                 |
| PerformRx Provider Relations Help Desk (Contracting Issues Only): 1-800-555-5690   |                                 |
| PerformRx Provider Relations Contact: <a href="mailto:pharmacynetworkcontracting@performrx.com">pharmacynetworkcontracting@performrx.com</a> |                                 |
| Providers Portal: <a href="https://prx.darwinrx.com/providers">https://prx.darwinrx.com/providers</a>  |                                 |
| Abarca Technical Issues (POS, Provider Portal Connectivity Issues Only): 1-866-286-6765  |                                 |

### Supported Transmissions

|    |                |
|----|----------------|
| B1 | Claim Billing  |
| B2 | Claim Reversal |

**Overview**

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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  |
| <b>Data Dictionary</b><br>Full reference to all fields and values used in the NCPDP standard with examples. |
| <b>External Code List</b><br>Full reference to values used in the NCPDP standard.                           |

**Segment & Field Designation**

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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     | <b>Mandatory</b><br>Fields required in accordance with the NCPDP Telecommunication Implementation Guide Version D.Ø.  |
| R     | <b>Required</b><br>Fields defined as situational by the NCPDP Telecommunication Implementation Guide Version D.Ø but required by Abarca Health’s processor.   |
| RW    | <b>Required When</b><br>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     | <b>Optional</b><br>Field may or may not be sent.  |
| **R** | <b>Repetition</b><br>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.

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           | PRX01825<br>*MPPP01825 | *To bill applicable claims under the Medicare Prescription Payment plan, please use PCN MPPP01825. |
| 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<br>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 | O           | Y or N   | Y = Yes (CMS qualified)<br>N = No (Not CMS qualified)<br>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<br>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          | Ø, 1, 3, 4, 6, 9, 11 | Refer to External Code List for value definitions.<br>Ø = Not Specified<br>1 = Home/Nursing Facility<br>3 = Assisted Living Facility<br>6 = Group Home<br>9 = Intermediate Care Facility / Mentally Retarded<br>11 = Hospice |

**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   |
| 4Ø2-D2   | Prescription / Service Reference Number           | M           |          |  |
| 436-E1   | Product / Service ID Qualifier                    | M           | ØØ or Ø3 | Ø3 = NDC<br>ØØ = Multi-Ingredient Compound billing   |
| 4Ø7-D7   | Product / Service ID                              | M           |          | National Drug Code (NDC).<br>Use Ø (zero) for multi-ingredient (compound) prescriptions.<br>Format = MMMMMDDDDPP |

| Field ID | Name   | Designation | Value(s) | Comments   |
|----------|--|-------------|----------|--|
| 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.<br><br>Required if transaction is the "completion" transaction in a partial fill<br>(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.<br><br>Required if transaction is the "completion" transaction in a partial fill<br>(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<br>1 to 99 = Refill number  |
| 405-D5   | Days Supply  | R           |          |  |
| 406-D6   | Compound Code                                      | R           | 1 or 2   | 1 = Not Compound<br>2 = Compound<br>Ø is not an acceptable value and will be rejected.   |
| 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  | 0 = No Refills Authorized<br><br>1-99 = Authorized Refill Number – 99 being as needed refills  |
| 419-DJ   | Prescription Origin Code                           | RW          | 1 to 5   | 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   |

| Field ID | Name                                | Designation | Value(s)   | Comments  |
|----------|-------------------------------------|-------------|--|---|
|          |                                     |             |  | <p>Number is 01 – 99 (Refill Prescription), the POC may be submitted with values of 1 – 5.</p> <p>1 = Written<br/>2 = Telephone<br/>3 = Electronic<br/>4 = Facsimile<br/>5 = Pharmacy</p>   |
| 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          |  | <p>Required if clarification is needed and value submitted is greater than zero (Ø).</p> <p>SCC usage is based upon NCPDP guidance.</p> <p>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.</p> <p>Some LTC scenarios require SCC codes to process – SCC values 13-17, 21-36 will be accepted</p> <p>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.</p> |
| 3Ø8-C8   | Other Coverage Code                 | RW          | <p>0= Not Specified<br/>1—No other coverage identified<br/>2=Other coverage exists- payment collected<br/>3= other coverage exists- this claim not covered<br/>4= other coverage exists- payment not collected</p> | <p>Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers.</p> <p>Required for Coordination of Benefits.</p> <p>Allow OCC 0,1,2,3, and 4</p> <p>*For COB billing under the Medicare Prescription Payment Plan, please see the section for Medicare Prescription Payment Plan (MPPP) COB Billing; only OCC 8 accepted.</p>   |
| 461-EU   | Prior Authorization Type Code       | RW          | 1  | 1 = Prior Authorization   |

| Field ID | Name                                 | Designation | Value(s)   | Comments   |
|----------|--------------------------------------|-------------|------------|--|
|          |                                      |             |            | 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 | 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<br><br>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   |
| 409-D9   | Ingredient Cost Submitted | R           |          |   |
| 412-DC   | Dispensing Fee Submitted  | RW          |          | Required if its value has an effect on the Gross Amount Due (430-DU) calculation. |

| Field ID | Name                                     | Designation | Value(s)           | Comments  |
|----------|--|-------------|--------------------|---|
| 433-DX   | Patient Paid Amount Submitted            | RW          |                    | 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 | Required if Other Amount Claimed Submitted Qualifier (479-H8) is used   |
| 479-H8   | Other Amount Claimed Submitted Qualifier | RW          |                    | Required if Other Amount Claimed Submitted (480-H9) is used   |
| 480-H9   | Other Amount Claimed Submitted           | RW          |                    | Required if its value has an effect on the Gross Amount Due (430-DU) calculation.   |
| 438-E3   | Incentive Amount Submitted               | O           |                    |   |
| 426-DQ   | Usual And Customary Charge               | RW          |                    | Required when there's a trading partner agreement.  |
| 430-DU   | Gross Amount Due                         | R           |                    | GAD Required.<br>Necessary for plan benefit administration.   |
| 423-DN   | Basis of Cost Determination              | R           |                    |   |
| 481-HA   | Flat Sales Tax Amount Submitted          | RW          |                    | Required if its value has an effect on the Gross Amount Due (430-DU) calculation.   |
| 482-GE   | Percentage Sales Tax Amount Submitted    | RW          |                    | Required if its value has an effect on the Gross Amount Due (430-DU) calculation.<br><br>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 if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used.<br><br>Required if this field could result in different pricing.<br><br>Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX). |
| 484-JE   | Percentage Sales Tax Basis Submitted     | RW          |                    | Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used.<br><br>Required if this field could result in different pricing.<br><br>Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).  |

**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       | Ø1 = National Provider ID (NPI)  |
| 411-DB   | Prescriber ID                       | R           |          | Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs.<br><br>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 processing for will be based on Payer responsibility for claims billed to the Part D PCN. Only OPAP (Other Payer Amount Paid) method will be supported - current payer is billed the balance from other primary payers to determine coverage.

Please refer to the Medicare Prescription Payment Plan (MPPP) COB Billing section for specific COB-billing information for MPPP claims, which only supports the OPPRA (Other Payer Patient Responsibility Amount) method.

| 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.                                |

| Field ID | Name                              | Designation | Value(s)           | Comments  |
|----------|-----------------------------------|-------------|--------------------|---|
| 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.   |
| 431-DV   | Other Payer Amount Paid           | RW          |                    | Required if other payer has approved payment for some/all of the billing.<br>Not used for patient financial responsibility only billing.<br>Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. |
| 471-5E   | Other Payer Reject Count          | RW          | 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 (308-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 | Required if DUR/PPS Segment is used.   |
| 439-E4   | Reason for Service Code   | RW          |                    | Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.<br>Required if this field affects payment for or documentation of professional pharmacy service. |
| 440-E5   | Professional Service 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 or documentation of professional pharmacy service.<br><br>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.<br><br>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           |          |  |
| 451-EG   | Compound Dispensing Unit Form Indicator         | M           |          | 1 = Each<br>2 = Grams<br>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**      |          | 03 = 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 | 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          |                    | Required if Diagnosis Code (424- DO) is used.<br>Payer Requirement: (Same as Imp Guide).  |
| 424-DO   | Diagnosis Code           | RW          |                    | Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.<br><br>Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization.<br><br>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.

\*Note, a Medicare Prescription Payment Plan reversal request must be processed prior to the Part D reversal request following NCPDP guidance for appropriate COB reversal order.

### 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           | PRX01825<br>*MPPP01825 | *To bill applicable reversal requests under the Medicare Prescription Payment plan, please use PCN MPPP01825. |
| 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<br>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  |
|----------|--------------------------|-------------|----------|---|
| 545-2F   | Network Reimbursement ID | RW          |          | <p>Imp Guide: Required if needed to identify the network for the covered member.</p> <p>Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available.</p> <p>Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist</p> |

**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<br>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<br>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<br>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<br>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<br>D = Duplicate of Paid<br>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<br>A = Approved<br>D = Duplicate of Paid<br>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          | 001, 002, 003, 004, 005, 006, 019, 021 | 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          | Maximum count of 25                    | Required when Additional Message Information (526-FQ) is used.   |
| 132-UH   | Additional Message Information Qualifier  | RW<br>**R** | 01 to 09                               | Refer to External Code List for value definitions. Required when Additional Message Information (526-FQ) is used.  |
| 526-FQ   | Additional Message Information            | RW<br>**R** |  | Required when additional text is needed for clarification or detail.   |
| 131-UG   | Additional Message Information Continuity | RW<br>**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          | 03                                     | 03 = Processor / PBM<br>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          | Maximum count of 6 | Required when Preferred Product ID (553-AR) is used.                                |
| 552-AP   | Preferred Product ID Qualifier                    | RW<br>**R** | 03                 | 03 = 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        | 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 0 (zero) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final |

| Field ID | Name                                  | Designation | Value(s)           | Comments  |
|----------|---------------------------------------|-------------|--------------------|---|
|          |                                       |             |                    | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.  |

| Field ID | Name  | Designation | Value(s)           | Comments  |
|----------|---|-------------|--------------------|---|
| 518-FI   | Amount of Copay                                     | RW          |                    | Required when the Patient Pay Amount (505-F5) includes copay as patient financial responsibility.   |
| 520-FK   | Amount Exceeding Periodic Benefit Maximum           | RW          |                    | Required when the Patient Pay Amount (505-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.   |
| 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.<br>Ø1 = Deductible<br>Ø2 = Initial Benefit<br>Ø3 = Coverage Gap<br>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.<br><br>Required if necessary for state/federal/regulatory agency programs |
| 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.   |
| 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 |

| Field ID | Name                            | Designation | Value(s)           | Comments  |
|----------|---------------------------------|-------------|--------------------|---|
| 567-J6   | DUR / PPS Response Code Counter | RW<br>**R** | Maximum count of 9 | Required when segment is used.  |
| 439-E4   | Reason for Service Code         | RW<br>**R** |                    | Required when utilization conflict is detected.<br>Refer to External Code List for all possible values.   |
| 528-FS   | Clinical Significance Code      | RW<br>**R** |                    | Required when needed to supply additional information for the utilization conflict.<br>1 = Major<br>2 = Moderate<br>3 = Minor<br>9 = Undetermined |
| 53Ø-FU   | Previous Date Filled            | RW<br>**R** |                    | CCYYMMDD format. Required when needed to supply additional information for the utilization conflict.  |
| 531-FV   | Quantity of Previous Fill       | RW<br>**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<br>**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<br>**R** |                    | Ø3 = Bank Information Number (BIN)<br>Required when Other Payer ID (34Ø-7C) is used.   |
| 34Ø-7C   | Other Payer ID            | RW<br>**R** |                    | Bank Information Number (BIN). Required when the other payer has BIN.<br>Imp Guide: Required if other insurance information is available for coordination of benefits. |

| Field ID | Name                                 | Designation | Value(s) | Comments  |
|----------|--------------------------------------|-------------|----------|---|
| 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.  |

**Additional Information**

**Medicare Prescription Payment Plan (MPPP) COB Billing**

Under the MPPP program, claims must be submitted utilizing the Other Payer Patient Responsibility Amount (OPRA) COB billing method with an Other Coverage Code of 8 (Claim is billing for patient financial responsibility only):

| 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<br>**R**  | Ø1 to Ø9               | Refer to External Code List for value definitions.   |
| 339-6C   | Other Payer ID Qualifier                             | R<br>**R**  | Ø1, Ø2, Ø3, Ø4, Ø5, 99 | Refer to External Code List for value definitions.   |
| 34Ø-7C   | Other Payer ID                                       | R<br>**R**  |                        |  |
| 443-E8   | Other Payer Date                                     | O<br>**R**  |                        | CCYYMMDD format  |
| 353-NR   | Other Payer- Patient Responsibility Amount Count     | N           | 1 to 25                | Required for MPPP. Maximum count of 25.  |
| 351-NP   | Other Payer- Patient Responsibility Amount Qualifier | R<br>**R**  | Refer to ECL           | Required for MPPP. 06 (Patient Pay Amount (505-F5) as reported by previous payer) preferred. |
| 352-NQ   | Other Payer- Patient Responsibility Amount           | R<br>**R**  |                        | Required for MPPP.   |
| 392-MU   | Benefit Stage Count                                  | R           |                        | Required for MPPP.   |
| 393-MV   | Benefit Stage Qualifier                              | R           |                        | Required for MPPP.   |
| 394-MW   | Benefit Stage Amount                                 | R           |                        | Required for MPPP.   |
| 341-HB   | Other Payer Amount Paid Count                        | N           | 1 to 9                 | Not Used for MPPP.   |
| 342-HC   | Other Payer Amount Paid Qualifier                    | N           |                        | Not Used for MPPP.   |
| 431-DV   | Other Payer Amount Paid                              | N           |                        | Not Used for MPPP.   |
| 471-5E   | Other Payer Reject Count                             | N           | 1 to 5                 | Not Used for MPPP.   |
| 472-6E   | Other Payer Reject Code                              | N           |                        | Not Used for MPPP.   |

