

Idaho Medicaid NCPDP D.0 Payer Specifications

July 24, 2020

****Start of Request Claim Billing/Claim Re-bill (B1/B3) Payer Sheet****

General Information

Payer Name: Idaho Medicaid		
Plan Name/Group Name: ID01/IDMEDICAID	BIN: 014864	PCN: P043014864
Processor: Magellan Rx Management		
Effective as of: 01/01/2012	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: June, 2010	NCPDP External Code List Version Date: June, 2010	
Contact/Information Source: https://idaho.fhsc.com/		
Certification Testing Window: TBD		
Provider Relations Help Desk Info: 800-922-3987		
Other versions supported: NCPDP Telecommunication version 5.1 until 12/31/2011		

Other Transactions Supported

Payer: Please list each transaction supported with the segments, fields, and pertinent information on each transaction.

Transaction Code	Transaction Name
B1	Billing
B2	Reversal
B3	Re-bill
E1	Eligibility Verification

Field Legend for Columns

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	R	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	RW	"Required when" the situations designated have qualifications for usage ("Required if x," "Not required if y").	Yes

Proprietary & Confidential

© 2012–2020 Magellan Health, Inc. All rights reserved.

Magellan Medicaid Administration, part of the Magellan Rx Management division of Magellan Health, Inc.

Fields that are not used in the Claim Billing/Claim Re-bill transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

Claim Billing/Claim Re-bill Transaction

The following lists the segments and fields in a Claim Billing or Claim Re-bill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

Transaction Header Segment Questions		Check	Claim Billing/Claim Re-bill If Situational, Payer Situation	
This Segment is always sent		X		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued		X		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN issued				
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used				

Transaction Header Segment		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN Number	014864	M	
101-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	<ul style="list-style-type: none"> • B1 • B2 • B3 • E1 	M	<ul style="list-style-type: none"> • B1 Billing • B2 Reversal • B3 Re-bill • E1 Eligibility
104-A4	PROCESSOR CONTROL NUMBER	P043014864	M	
109-A9	TRANSACTION COUNT	<ul style="list-style-type: none"> • 01 = One occurrence • 02 = Two occurrences • 03 = Three occurrences • 04 = Four occurrences 	M	

Transaction Header Segment		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1	M	Code qualifying the “Service Provider ID” (2Ø1-B1) Ø1 – National Provider Identifier (NPI)
2Ø1-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
4Ø1-D1	DATE OF SERVICE	Format = CCYYMMDD	M	
11Ø	SOFTWARE VENDOR/CERTIFICATION ID		RW	Certification ID is not required.

Insurance Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This segment is always sent	X	

Insurance Segment Segment Identification (111 AM) = “Ø4”		Claim Billing/Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
3Ø2-C2	CARDHOLDER ID	Medicaid ID Number	M	Medicaid ID Number <patient specific>
3Ø1-C1	GROUP ID	IDMEDICAID	R	<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs. Required if needed for pharmacy claim processing and payment. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
36Ø-2B	MEDICAID INDICATOR	Two character State Postal Code indicating the state where Medicaid coverage exists.	RW	<i>Imp Guide:</i> Required, if known, when patient has Medicaid coverage. Example: ID
115-N5	MEDICAID ID NUMBER	ID MEDICAID ID <PATIENT SPECIFIC>	RW	<i>Imp Guide:</i> Required, if known, when patient has Medicaid coverage.

Patient Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<p>The Patient Segment is situational for a Claim Billing or Encounter request. It is used when a receiver needs some of the patient demographic information to perform eligibility and claim/encounter determination. The Patient Segment must be submitted when needed to differentiate between the patient and the cardholder. If the cardholder and the patient are the same, then the Patient Segment is not submitted unless additional information about the patient is needed to clarify the claim/encounter determination.</p> <p>The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.</p>

Patient Segment Segment Identification (111 AM) = "Ø1"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
331-CX	PATIENT ID QUALIFIER	<ul style="list-style-type: none"> • Ø1 = Social Security Number • 1J = Facility ID Number • Ø2 = Driver's License Number • Ø3 = US Military ID • Ø4 = Non-SSN-based patient identifier assigned by health plan • Ø5 = SSN-based patient identifier assigned by health plan • Ø6 = Medicaid ID • Ø7 = State Issued ID 	RW	<p><i>Imp Guide:</i> Required if Patient ID (332-CY) is used.</p> <p><i>Payer Requirement:</i> Same as <i>Imp Guide</i>.</p>

Patient Segment Segment Identification (111 AM) = "Ø1"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
		<ul style="list-style-type: none"> • Ø8 = Passport ID • Ø9 = Medicare HIC# • 1Ø = Employer Assigned ID • 11 = Payer/PBM Assigned ID • 12 = Alien Number • 13 = Government Student VISA Number • 14 = Indian Tribal ID • 99 = Other • EA = Medical Record Identification Number (EHR) 		
332-CY	PATIENT ID		RW	<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs to validate dual eligibility. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
3Ø4-C4	DATE OF BIRTH	Format = CCYYMMDD	R	
3Ø5-C5	PATIENT GENDER CODE	<ul style="list-style-type: none"> • Ø = Not Specified • 1 = Male • 2 = Female 	R	
31Ø-CA	PATIENT FIRST NAME		R	<i>Imp Guide:</i> Required when the patient has a first name. <i>Payer Requirement:</i> Required for a patient name validation.
311-CB	PATIENT LAST NAME		R	<i>Imp Guide:</i> Required when the patient has a last name. <i>Payer Requirement:</i> Required for a patient name validation.
322-CM	PATIENT STREET ADDRESS		RW	<i>Imp Guide:</i> Optional. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
323-CN	PATIENT CITY ADDRESS		RW	<i>Imp Guide:</i> Optional.

Patient Segment Segment Identification (111 AM) = "Ø1"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
				<i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
324-CO	PATIENT STATE / PROVINCE ADDRESS		RW	<i>Imp Guide:</i> Optional. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
325-CP	PATIENT ZIP/POSTAL ZONE		RW	<i>Imp Guide:</i> Optional. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
326-CQ	PATIENT PHONE NUMBER		RW	<i>Imp Guide:</i> Optional. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
335-2C	PREGNANCY INDICATOR	<ul style="list-style-type: none"> • Blank = Not Specified • 1 = Not Pregnant • 2 = Pregnant 	RW	<i>Imp Guide:</i> Required if pregnancy could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
384-4X	PATIENT RESIDENCE	<ul style="list-style-type: none"> • Ø = Not Specified • 1 = Home • 2 = Skilled Nursing Facility. PART B ONLY • 3 = Nursing Facility • 4 = Assisted Living Facility • 5 = Custodial Care Facility. PART B ONLY • 6 = Group Home • 7 = Inpatient Psychiatric Facility • 8 = Psychiatric Facility – Partial Hospitalization • 9 = Intermediate Care Facility/Mentally Retarded • 1Ø = Residential 	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Patient Segment Segment Identification (111 AM) = "Ø1"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
		Substance Abuse Treatment Facility <ul style="list-style-type: none"> • 11 = Hospice • 12 = Psychiatric Residential Treatment Facility • 13 = Comprehensive Inpatient Rehabilitation Facility • 14 = Homeless Shelter • 15 = Correctional Institution 		

Claim Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent	X	
This payer supports partial fills	X	
This payer does not support partial fills		

Claim Segment Segment Identification (111 AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	<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)
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	<ul style="list-style-type: none"> • ØØ = Not specified • Ø3 = National Drug Code (NDC) 	M	
4Ø7-D7	PRODUCT/SERVICE ID	NDC for non-compound claims "Ø" for compound claims	M	

Claim Segment Segment Identification (111 AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER		RW	<i>Imp Guide:</i> Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE		RW	<i>Imp Guide:</i> Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if Associated Prescription/Service Reference Number (456-EN) is used. Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
442-EF	QUANTITY DISPENSED	Metric Decimal Quantity	R	
460-ET	QUANTITY PRESCRIBED		RW	<i>Imp Guide:</i> Required when a transmission is for a Scheduled II drug as defined in 21 CFR 1308.12 and per CMS-0055-F (Compliance Date 09/21/2020. Refer to the <i>Version D.0 Editorial Document</i>).
4Ø3-D3	FILL NUMBER	<ul style="list-style-type: none"> • Ø = Original dispensing • 1-99 = Refill number – Number of the 	R	

Claim Segment Segment Identification (111 AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
		replenishment		
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	<ul style="list-style-type: none"> • 1 = Not a Compound • 2 = Compound 	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	<ul style="list-style-type: none"> • Ø = No Product Selection Indicated • 1 = Substitution Not Allowed by Prescriber • 2 = Substitution Allowed-Patient Requested Product Dispensed • 3 = Substitution Allowed-Pharmacist Selected Product Dispensed • 4 = Substitution Allowed-Generic Drug Not in Stock • 5 = Substitution Allowed-Brand Drug Dispensed as a Generic • 6 = Override • 7 = Substitution Not Allowed-Brand Drug Mandated by Law • 8 = Substitution Allowed-Generic Drug Not Available in Marketplace • 9 = Substitution Allowed By Prescriber but Plan Requests Brand-Patient's Plan Requested Brand Product To Be Dispensed 	R	

Claim Segment Segment Identification (111 AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED	<ul style="list-style-type: none"> • Ø = No refills authorized • 1-99 = Authorized Refill number – with 99 being as needed, refills unlimited 	R	<i>Imp Guide:</i> Required if necessary for plan benefit administration. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
419-DJ	PRESCRIPTION ORIGIN CODE	<ul style="list-style-type: none"> • Ø = Not Known • 1 = Written • 2 = Telephone • 3 = Electronic • 4 = Facsimile • 5 = Pharmacy 	R	<i>Imp Guide:</i> Required if necessary for plan benefit administration. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3	RW***	<i>Imp Guide:</i> Required if Submission Clarification Code (42Ø-DK) is used. <i>Payer Requirement:</i> Required if field 42Ø-DK is sent.
42Ø-DK	SUBMISSION CLARIFICATION CODE	<ul style="list-style-type: none"> • 1 = No Override • 2 = Other Override • 3 = Vacation Supply • 4 = Lost Prescription • 5 = Therapy Change • 6 = Starter Dose • 7 = Medically Necessary • 8 = Process Compound for Approved Ingredients • 9 = Encounters • 1Ø = Meets Plan Limitations • 11 = Certification on File • 12 = DME Replacement Indicator • 13 = Payer 	RW	<i>Imp Guide:</i> Required if clarification is needed and value submitted is greater than zero (Ø). If the Date of Service (4Ø1-D1) contains the subsequent payer coverage date, the Submission Clarification Code (42Ø-DK) is required with value of "19" (Split Billing – indicated the quantity dispensed as the remainder billed to a subsequent payer when Medicare Part A expires. Used only in a long-term care settlements) for individual unit of use medications. <i>Payer Requirement:</i> Required when need to provide

Claim Segment Segment Identification (111 AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
		Recognized Emergency/Disaster Assistance Request <ul style="list-style-type: none"> • 14 = Long Term Care Leave of Absence • 15 = Long Term Care Replacement Medication • 16 = Long Term Care Emergency box (kit) or automated dispensing machine • 17 = Long Term Care Emergency supply remainder • 18 = Long Term Care Patient Admit/Readmit Indicator • 19 = Split Billing • 2Ø = 34ØB • 99 = Other 		additional information for coverage purposes. (Include a value of "8" when submitting a compound claim.)
3Ø8-C8	OTHER COVERAGE CODE	<ul style="list-style-type: none"> • Ø = Not Specified by patient • 2 = Other coverage exists-payment collected • 3 = Other Coverage Billed - claim not covered • 4 = Other coverage exists-payment not collected 	RW	<i>Imp Guide:</i> 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. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
429-DT	SPECIAL PACKAGING INDICATOR	<ul style="list-style-type: none"> • Ø = Not Specified • 1 = Not Unit Dose • 2 = Manufacturer Unit Dose • 3 = Pharmacy Unit Dose • 4 = Custom 	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Claim Segment Segment Identification (111 AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
		Packaging <ul style="list-style-type: none"> • 5 = Multi-drug compliance packaging 		
6ØØ-28	UNIT OF MEASURE	<ul style="list-style-type: none"> • EA = Each • GM = Grams • ML = Milliliters 	R	<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs. Required if this field could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
481-DI	LEVEL OF SERVICE	<ul style="list-style-type: none"> • Ø = Not Specified • 1 = Patient consultation • 2 = Home delivery • 3 = Emergency • 4 = 24 hour service • 5 = Patient consultation regarding generic product selection • 6 = In-Home Service 	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
461-EU	PRIOR AUTHORIZATION TYPE CODE	<ul style="list-style-type: none"> • Ø = Not Specified • 1 = Prior Authorization • 2 = Medical Certification • 3 = EPSDT (Early Periodic Screening Diagnosis Treatment) • 4 = Exemption from Co-pay and/or Co-insurance • 5 = Exemption from RX • 6 = Family Planning 	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Claim Segment Segment Identification (111 AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
		Indicator <ul style="list-style-type: none"> • 7 = TANF (Temporary Assistance for Needy Families) • 8 = Payer Defined Exemption • 9 = Emergency Preparedness 		
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
343-HD	DISPENSING STATUS	<ul style="list-style-type: none"> • P = Partial Fill • C = Completion of Partial Fill 	RW	<i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	<i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	<i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
995-E2	ROUTE OF ADMINISTRATION	SNOMED	RW	<i>Imp Guide:</i> Required if specified in trading partner agreement. <i>Payer Requirement:</i> Required when submitting compounds.
996-G1	COMPOUND TYPE	<ul style="list-style-type: none"> • Ø1 = Anti-infective • Ø2 = Iontropic • Ø3 = Chemotherapy 	RW	<i>Imp Guide:</i> Required if specified in trading partner agreement.

Claim Segment Segment Identification (111 AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situations
		<ul style="list-style-type: none"> • Ø4 = Pain management • Ø5 = TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/Peripheral Parenteral Nutrition • Ø6 = Hydration • Ø7 = Ophthalmic • 99 = Other 		<i>Payer Requirement:</i> Required when submitting compounds.
147-U7	PHARMACY SERVICE TYPE	<ul style="list-style-type: none"> • 1 = Community/Retail Pharmacy Services • 2 = Compounding Pharmacy Services • 3 = Home Infusion Therapy Provider Services • 4 = Institutional Pharmacy Services • 5 = Long Term Care Pharmacy Services • 6 = Mail Order Pharmacy Services • 7 = Managed Care Organization Pharmacy Services • 8 = Specialty Care Pharmacy Services • 99 = Other 	RW	<i>Imp Guide:</i> Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

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

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

Pricing Segment Segment Identification (111-AM) = "11"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (430-DU) calculation. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
433-DX	PATIENT PAID AMOUNT SUBMITTED		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted Qualifier (479-H8) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	<ul style="list-style-type: none"> • Ø1 = Delivery Cost • Ø2 = Shipping Cost • Ø3 = Postage Cost • Ø4 = Administrative Cost • Ø9 = Compound Preparation Cost Submitted • 99 = Other 	RW	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted (480-H9) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
480-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (430-DU) calculation. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
426-DQ	USUAL AND CUSTOMARY CHARGE		R	<i>Imp Guide:</i> Required if needed per trading partner agreement. <i>Payer Requirement:</i> Required for claim processing.
430-DU	GROSS AMOUNT DUE		R	<i>Payer Requirement:</i> Gross Amount Due = Ingredient

Pricing Segment Segment Identification (111-AM) = "11"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Cost submitted + Dispensing Fee Submitted.
423-DN	BASIS OF COST DETERMINATION	<ul style="list-style-type: none"> • ØØ = Default • Ø1 = AWP • Ø2 = Local Wholesaler • Ø3 = Direct • Ø4 = EAC (Estimated Acquisition Cost) • Ø5 = Acquisition • Ø6 = MAC (Maximum Allowable Cost) • Ø7 = Usual & Customary • Ø8 = 34ØB/ Disproportionate Share Pricing • Ø9 = Other • 1Ø = ASP (Average Sales Price) • 11 = AMP (Average Manufacturer Price) • 12 = WAC (Wholesale Acquisition Cost) • 13 = Special Patient Pricing 	RW	<i>Imp Guide:</i> Required if needed for receiver claim/encounter adjudication. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Prescriber Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Prescriber Segment Segment Identification (111-AM) = "Ø3"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	Ø1	R	<i>Imp Guide:</i> Required if Prescriber ID (411-DB) is used. Ø1 = National Provider

Prescriber Segment Segment Identification (111-AM) = "Ø3"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Identifier (NPI) <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
411-DB	PRESCRIBER ID	NPI	R	<i>Imp Guide:</i> Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement:</i> Required for claim submission.
427-DR	PRESCRIBER LAST NAME		RW	<i>Imp Guide:</i> Required when the Prescriber ID (411-DB) is not known. Required if needed for Prescriber ID (411-DB) validation/clarification. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc. claims. It is used when a receiver needs payment information from other receivers to perform claim/encounter determination. This may be in the case of primary, secondary, tertiary et cetera health plan coverage for example. The Coordination of Benefits/Other Payments Segment is mandatory for a Claim Billing or Encounter request to a downstream payer. It is used to assist a downstream payer to uniquely identify a claim or encounter in case of duplicate processing.

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
		The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.
Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		

If the Payer supports the Coordination of Benefits/Other Payments Segment, only one scenario method shown above may be supported per template. The template shows the Coordination of Benefits/Other Payments Segment that must be used for each scenario method. The Payer must choose the appropriate scenario method with the segment chart, and delete the other scenario methods with their segment charts. See section [Coordination of Benefits \(COB\) Processing](#) for more information.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-bill Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE	<ul style="list-style-type: none"> • Blank = Not Specified • Ø1 = Primary – First • Ø2 = Secondary – Second • Ø3 = Tertiary – Third • Ø4 = Quaternary – Fourth • Ø5 = Quinary – Fifth • Ø6 = Senary – Sixth • Ø7 = Septenary – Seventh • Ø8 = Octonary – Eighth • Ø9 = Nonary – Ninth 	M	

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-bill Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
339-6C	OTHER PAYER ID QUALIFIER	99 = Other	RW	<i>Imp Guide:</i> Required if Other Payer ID (34Ø-7C) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
34Ø-7C	OTHER PAYER ID		RW	<i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
443-E8	OTHER PAYER DATE		RW	<i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW***	<i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	<ul style="list-style-type: none"> • Ø1 = Delivery • Ø2 = Shipping • Ø3 = Postage • Ø4 = Administrative • Ø5 = Incentive • Ø6 = Cognitive Service • Ø7 = Drug Benefit • Ø9 = Compound Preparation Cost Submitted • 1Ø = Sales Tax 	RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
431-DV	OTHER PAYER AMOUNT PAID		RW	<i>Imp Guide:</i> Required if other payer has approved payment for some/all of the billing. Not used for patient financial

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-bill Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW***	<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
472-6E	OTHER PAYER REJECT CODE		RW	<i>Imp Guide:</i> 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). <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW***	<i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	<ul style="list-style-type: none"> • Blank = Not Specified • Ø1 = Amount Applied to Periodic Deductible (517-FH) as reported by previous payer • Ø2 = Amount Attributed to Product Selection/Brand 	RW	<i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-bill Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		Drug (134-UK) as reported by previous payer <ul style="list-style-type: none"> • Ø3 = Amount Attributed to Sales Tax (523-FN) as reported by previous payer • Ø4 = Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer • Ø5 = Amount of Co-pay (518-FI) as reported by previous payer • Ø6 = Patient Pay Amount (5Ø5-F5) as reported by previous payer • Ø7 = Amount of Coinsurance (572-4U) as reported by previous payer • Ø8 = Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer • Ø9 = Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer • 1Ø = Amount 		

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-bill Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		<p>Attributed to Provider Network Selection (133-UJ) as reported by previous payer</p> <ul style="list-style-type: none"> • 11 = Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer • 12 = Amount Attributed to Coverage Gap (137-UP) that was collected from the patient due to a coverage gap • 13 = Amount Attributed to Processor Fee (571-NZ) as reported by previous payer 		
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	<p><i>Imp Guide:</i> Required if necessary for patient financial responsibility only billing. Required if necessary for state/federal/regulatory agency programs. Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted.</p> <p><i>Payer Requirement:</i> Same as <i>Imp Guide</i>.</p>

DUR/PPS Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	It is used when a sender notifies the receiver of drug utilization, drug evaluations, or information on the appropriate selection to process the claim/encounter. The DUR/PPS information may be sent on the initial submission or alternatively sent after a DUR/PPS rejection from a receiver. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	R***	<i>Imp Guide:</i> Required if DUR/PPS Segment is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
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. <i>Payer Requirement:</i> Required when needed to communicate DUR information.
44Ø-E5	PROFESSIONAL SERVICE CODE		RW***	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. <i>Payer Requirement:</i> Required when needed to communicate DUR information.
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. <i>Payer Requirement:</i> Required when needed to communicate DUR information.
474-8E	DUR/PPS LEVEL OF EFFORT	<ul style="list-style-type: none"> • Ø = Not Specified • 11 = Level 1 (Lowest) • 12 = Level 2 • 13 = Level 3 • 14 = Level 4 • 15 = Level 5 (Highest) 	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. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
Compound Segment Questions		Check	Claim Billing/Claim Re-bill If Situational, Payer Situation	
This Segment is always sent				

This Segment is situational	X	It is used for multi-ingredient prescriptions, when each ingredient is reported.
-----------------------------	---	--

Compound Segment Segment Identification (111-AM) = "1Ø"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	<ul style="list-style-type: none"> • Blank = Not Specified • Ø1 = Capsule • Ø2 = Ointment • Ø3 = Cream • Ø4 = Suppository • Ø5 = Powder • Ø6 = Emulsion • Ø7 = Liquid • 1Ø = Tablet • 11 = Solution • 12 = Suspension • 13 = Lotion • 14 = Shampoo • 15 = Elixir • 16 = Syrup • 17 = Lozenge • 18 = Enema 	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	<ul style="list-style-type: none"> • 1 = Each • 2 = Grams • 3 = Milliliters 	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3 = National Drug Code (NDC) - Formatted 11 digits (N)	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		M	<p><i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed.</p> <p><i>Payer Requirement:</i> Required for each ingredient.</p>

Compound Segment Segment Identification (111-AM) = "1Ø"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	<ul style="list-style-type: none"> • ØØ = Default • Ø1 = AWP • Ø2 = Local Wholesaler • Ø3 = Direct • Ø4 = EAC (Estimated Acquisition Cost) • Ø5 = Acquisition • Ø6 = MAC (Maximum Allowable Cost) • Ø7 = Usual & Customary • Ø8 = 34ØB/ Disproportionate Share Pricing • Ø9 = Other • 1Ø = ASP (Average Sales Price) • 11 = AMP (Average Manufacturer Price) • 12 = WAC (Wholesale Acquisition Cost) • 13 = Special Patient Pricing 	RW	<i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Clinical Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<p>It is used to specify diagnosis information associated with the Claim Billing or Encounter transaction.</p> <p>The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.</p>

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	<i>Imp Guide:</i> Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
492-WE	DIAGNOSIS CODE QUALIFIER	<ul style="list-style-type: none"> • ØØ = Not Specified • Ø1 = ICD9 • Ø2 = ICD1Ø • Ø3 = National Criteria Care Institute (NCCI) • Ø4 = The Systematized Nomenclature of Human and Veterinary Medicine (SNOMED) • Ø5 = Common Dental Terminology (CDT) • Ø6 = Medi-Span Product Line Diagnosis Code • Ø7 = American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV) • Ø8 = First DataBank Disease Code (FDBDX) • Ø9 = First DataBank FML Disease Identifier (FDB DxID) • 99 = Other 	RW***	<i>Imp Guide:</i> Required if Diagnosis Code (424-DO) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
424-DO	DIAGNOSIS CODE		RW***	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				<p>financial responsibility, and/or drug utilization review outcome.</p> <p>Required if this field affects payment for professional pharmacy service.</p> <p>Required if this information can be used in place of prior authorization.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> Required for all hospice patient claims.</p>
493-XE	CLINICAL INFORMATION COUNTER	Maximum 5 occurrences supported.	RW***	<p><i>Imp Guide:</i> Grouped with Measurement fields (Measurement Date (494-ZE), Measurement Time (495-H1), Measurement Dimension (496-H2), Measurement Unit (497-H3), Measurement Value (499-H4)).</p> <p><i>Payer Requirement:</i> Same as <i>Imp Guide</i>.</p>
494-ZE	MEASUREMENT DATE		RW***	<p><i>Imp Guide:</i> Required if necessary when this field could result in different coverage and/or drug utilization review outcome.</p> <p><i>Payer Requirement:</i> Same as <i>Imp Guide</i>.</p>
495-H1	MEASUREMENT TIME		RW***	<p><i>Imp Guide:</i> Required if Time is known or has impact on measurement.</p> <p>Required if necessary when this field could result in different coverage and/or</p>

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				drug utilization review outcome. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
496-H2	MEASUREMENT DIMENSION	<ul style="list-style-type: none"> • Blank = Not Specified • Ø1 = Blood Pressure (BP) • Ø2 = Blood Glucose • Ø3 = Temperature • Ø4 = Serum Creatinine (SCr) • Ø5 = Glycosylated Hemoglobin (HbA1c) • Ø6 = Sodium (Na+) • Ø7 = Potassium (K+) • Ø8 = Calcium (Ca++) • Ø9 = Serum Glutamic-Oxaloacetic Transaminase (SGOT) • 1Ø = Serum Glutamic-Pyruvic Transaminase (SGPT) • 11 = Alkaline Phosphatase • 12 = Theophylline • 13 = Digoxin • 14 = Weight • 15 = Body Surface Area (BSA) • 16 = Height • 17 = Creatinine Clearance (CrCl) • 18 = Cholesterol • 19 = Low Density Lipoprotein (LDL) • 2Ø = High Density Lipoprotein (HDL) 	RW***	<p><i>Imp Guide:</i> Required if Measurement Unit (497-H3) and Measurement Value (499-H4) are used.</p> <p>Required if necessary when this field could result in different coverage and/or drug utilization review outcome.</p> <p>Required if necessary for patient's weight and height when billing Medicare for a claim that includes a Certificate of Medical Necessity (CMN).</p> <p><i>Payer Requirement:</i> Same as <i>Imp Guide</i>.</p>

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		<ul style="list-style-type: none"> • 21 = Triglycerides (TG) • 22 = Bone Mineral Density (BMD T-Score) • 23 = Prothrombin Time (PT) • 24 = Hemoglobin (Hb; Hgb) • 25 = Hematocrit (Hct) • 26 = White Blood Cell Count (WBC) • 27 = Red Blood Cell Count (RBC) • 28 = Heart Rate • 29 = Absolute Neutrophil Count (ANC) • 30 = Activated Partial Thromboplastin Time (APTT) • 31 = CD4 Count • 32 = Partial Thromboplastin Time (PTT) • 33 = T-Cell Count • 34 = INR- International Normalized Ratio • 99 = Other 		
497-H3	MEASUREMENT UNIT	<ul style="list-style-type: none"> • Blank = Not Specified • Ø1 = Inches (In) • Ø2 = Centimeters (cm) • Ø3 = Pounds (lb) • Ø4 = Kilograms (kg) • Ø5 = Celsius (C) 	RW***	<i>Imp Guide:</i> Required if Measurement Dimension (496-H2) and Measurement Value (499-H4) are used. Required if necessary for patient's weight and height when billing Medicare for a claim that includes a

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		<ul style="list-style-type: none"> • Ø6 = Fahrenheit (F) • Ø7 = Meters squared (m²) • Ø8 = Milligrams per deciliter (mg/dl) • Ø9 = Units per milliliter (U/ml) • 1Ø = Millimeters of mercury (mmHg) • 11 = Centimeters squared (cm²) • 12 = Milliliters per minute (ml/min) • 13 = Percent (%) • 14 = Milliequivalents per milliliter (mEq/ml) • 15 = International units per liter (IU/L) • 16 = Micrograms per milliliter (mcg/ml) • 17 = Nanograms per milliliter (ng/ml) • 18 = Milligrams per milliliter (mg/ml) • 19 = Ratio • 2Ø = SI Units • 21 = Millimoles/liter (mmol/l) • 22 = Seconds • 23 = Grams per deciliter (g/dl) • 24 = Cells per cubic millimeter (cells/cu mm) • 25 = 1,ØØØ,ØØØ cells per cubic millimeter (million cells/cu mm) • 26 = Standard 		<p>Certificate of Medical Necessity (CMN).</p> <p>Required if necessary when this field could result in different coverage and/or drug utilization review outcome.</p> <p><i>Payer Requirement:</i> Same as <i>Imp Guide</i>.</p>

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		deviation • 27 = Beats per minute		
499-H4	MEASUREMENT VALUE		RW***	<i>Imp Guide:</i> Required if Measurement Dimension (496-H2) and Measurement Unit (497-H3) are used. Required if necessary for patient's weight and height when billing Medicare for a claim that includes a Certificate of Medical Necessity (CMN). Required if necessary when this field could result in different coverage and/or drug utilization review outcome. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Facility Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	It is used when these fields could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.

Facility Segment Segment Identification (111-AM) = "15"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
336-8C	FACILITY ID		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. <i>Payer Requirement:</i> Same as

Facility Segment Segment Identification (111-AM) = "15"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				<i>Imp Guide.</i>
385-3Q	FACILITY NAME		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
386-3U	FACILITY STREET ADDRESS		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
388-5J	FACILITY CITY ADDRESS		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
387-3V	FACILITY STATE/PROVINCE ADDRESS		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
389-6D	FACILITY ZIP/POSTAL ZONE		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.

Facility Segment Segment Identification (111-AM) = "15"		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				<i>Payer Requirement: Same as Imp Guide.</i>
End of Request Claim Billing/Claim Re-bill (B1/B3) Payer Sheet				

Response Claim Billing/Claim Re-bill Payer Sheet

Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) Response

****Start of Response Claim Billing/Claim Re-bill (B1/B3) Payer Sheet****

General Information

Payer Name: Idaho Medicaid		
Plan Name/Group Name: ID01/IDMEDICAID	BIN: 014864	PCN: P043014864

Claim Billing/Claim Re-bill PAID (or Duplicate of PAID) Response

The following lists the segments and fields in a Claim Billing or Claim Re-bill response (Paid or Duplicate of Paid) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Response Transaction Header Segment		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging.

Response Message Segment Segment Identification (111-AM) = "20"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Insurance Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Response Insurance Segment Segment Identification (111-AM) = "25"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
301-C1	GROUP ID	IDMEDICAID	RW	<i>Imp Guide:</i> Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available. Required to identify the actual group that was used when multiple group coverages exist. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
545-2F	NETWORK REIMBURSEMENT ID		RW	<i>Imp Guide:</i> 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

Response Insurance Segment Segment Identification (111-AM) = "25"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Reimbursement ID that was used when multiple Network Reimbursement IDs exist. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
568-J7	PAYER ID QUALIFIER		RW	<i>Imp Guide:</i> Required if Payer ID (569-J8) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
569-J8	PAYER ID		RW	<i>Imp Guide:</i> Required to identify the ID of the payer responding. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Patient Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Patient Segment Segment Identification (111-AM) = "29"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME		R	<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> Required for patient name validation.
311-CB	PATIENT LAST NAME		R	<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> Required for patient name validation.

Response Patient Segment Segment Identification (111-AM) = "29"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
304-C4	DATE OF BIRTH	Format - CCYYMMDD	R	<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Status Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	<ul style="list-style-type: none"> P = Paid D = Duplicate of Paid 	M	
503-F3	AUTHORIZATION NUMBER		RW	<i>Imp Guide:</i> Required if needed to identify the transaction. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.	RW***	<i>Imp Guide:</i> Required if Approved Message Code (548-6F) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
548-6F	APPROVED MESSAGE CODE		RW***	<i>Imp Guide:</i> Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW***	<i>Imp Guide:</i> Required if and only if 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. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Claim Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Response Claim Segment Segment Identification (111-AM) = "22"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	<i>Imp Guide:</i> For Transaction Code of "B1," in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response Pricing Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
505-F5	PATIENT PAY AMOUNT		R	Returned if the processor determines that the patient has payment responsibility for part/all of the claim.
506-F6	INGREDIENT COST PAID		R	Required if this value is used to arrive at the final

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				reimbursement.
507-F7	DISPENSING FEE PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
521-FL	INCENTIVE AMOUNT PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement. Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø). <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	RW***	<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
564-J3	OTHER AMOUNT PAID QUALIFIER		RW***	<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
565-J4	OTHER AMOUNT PAID		RW***	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement. Required if Other Amount Claimed Submitted (480-H9) is greater than zero (Ø). <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW***	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement. Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Coordination of Benefits/Other Payments Segment is supported. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
509-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		RW	<i>Imp Guide:</i> Required if Ingredient Cost Paid (506-F6) is greater than zero (0). Required if Basis of Cost Determination (432-DN) is submitted on billing. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT		RW	<i>Imp Guide:</i> Provided for informational purposes only. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
513-FD	REMAINING DEDUCTIBLE AMOUNT		RW	<i>Imp Guide:</i> Provided for informational purposes only. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
514-FE	REMAINING BENEFIT AMOUNT		RW	<i>Imp Guide:</i> Provided for informational purposes only. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes deductible <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
518-FI	AMOUNT OF COPAY		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes co-pay as patient financial responsibility. <i>Payer Requirement:</i> Same as

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				<i>Imp Guide.</i>
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes amount exceeding periodic benefit maximum. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
346-HH	BASIS OF CALCULATION—DISPENSING FEE		RW	<i>Imp Guide:</i> Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
347-HJ	BASIS OF CALCULATION—COPAY		RW	<i>Imp Guide:</i> Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
572-4U	AMOUNT OF COINSURANCE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes coinsurance as patient financial responsibility. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
573-4V	BASIS OF CALCULATION-COINSURANCE		RW	<i>Imp Guide:</i> Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response DUR/PPS Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW***	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
439-E4	REASON FOR SERVICE CODE		RW***	<i>Imp Guide:</i> Required if utilization conflict is detected. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
528-FS	CLINICAL SIGNIFICANCE CODE		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
529-FT	OTHER PHARMACY INDICATOR		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
530-FU	PREVIOUS DATE OF FILL		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
531-FV	QUANTITY OF PREVIOUS FILL		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (530-FU) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
532-FW	DATABASE INDICATOR		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
533-FX	OTHER PRESCRIBER INDICATOR		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
544-FY	DUR FREE TEXT MESSAGE		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
570-NS	DUR ADDITIONAL TEXT		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		RW	<i>Imp Guide:</i> Required if Other Payer ID (340-7C) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
340-7C	OTHER PAYER ID		RW	<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
356-NU	OTHER PAYER CARDHOLDER ID		RW	<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
992-MJ	OTHER PAYER GROUP ID		RW	<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
142-UV	OTHER PAYER PERSON CODE		RW	<i>Imp Guide:</i> Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number of the other payer to the receiver. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	<i>Imp Guide:</i> Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		RW	<i>Imp Guide:</i> Required when other coverage is known which is after the Date of Service submitted. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		RW	<i>Imp Guide:</i> Required when other coverage is known which is after the Date of Service submitted. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Claim Billing/Claim Re-bill Accepted/Rejected Response

Response Transaction Header Segment Questions		Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation	
This Segment is always sent		X		
Response Transaction Header Segment		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	
Response Message Segment Questions		Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation	
This Segment is always sent				
This Segment is situational				
Response Message Segment Identification (111-AM) = "2Ø"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Insurance Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational		

Response Insurance Segment Segment Identification (111-AM) = "25"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
301-C1	GROUP ID	IDMEDICAID	RW	<i>Imp Guide:</i> Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available. Required to identify the actual group that was used when multiple group coverages exist. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
545-2F	NETWORK REIMBURSEMENT ID		RW	<i>Imp Guide:</i> 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. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
568-J7	PAYER ID QUALIFIER		RW	<i>Imp Guide:</i> Required if Payer ID (569-J8) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Insurance Segment Segment Identification (111-AM) = "25"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
569-J8	PAYER ID		RW	<i>Imp Guide:</i> Required to identify the ID of the payer responding. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
302-C2	CARDHOLDER ID	ID Medicaid ID Number <patient specific>	RW	<i>Imp Guide:</i> Required if the identification to be used in future transactions is different from what was submitted on the request. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Patient Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Patient Segment Segment Identification (111-AM) = "29"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME		R	<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> Required for patient name validation.
311-CB	PATIENT LAST NAME		R	<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> Required for patient name validation.
304-C4	DATE OF BIRTH	Format – CCYYMMDD	R	<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Status Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		RW	<i>Imp Guide:</i> Required if needed to identify the transaction. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
131-UG	ADDITIONAL MESSAGE INFORMATION		RW***	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
	CONTINUITY			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. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
987-MA	URL		RW	<i>Imp Guide:</i> Provided for informational purposes only to relay health care communications via the Internet. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
Response Claim Segment Questions		Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation	
This Segment is always sent		X		

Response Claim Segment Segment Identification (111-AM) = "22"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	<i>Imp Guide:</i> For Transaction Code of "B1" or "B3", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW***	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
439-E4	REASON FOR SERVICE CODE		RW***	<i>Imp Guide:</i> Required if utilization conflict is detected. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
528-FS	CLINICAL SIGNIFICANCE CODE		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
529-FT	OTHER PHARMACY INDICATOR		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
530-FU	PREVIOUS DATE OF FILL		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
531-FV	QUANTITY OF PREVIOUS FILL		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (530-FU) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
532-FW	DATABASE INDICATOR		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
533-FX	OTHER PRESCRIBER INDICATOR		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
544-FY	DUR FREE TEXT MESSAGE		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
570-NS	DUR ADDITIONAL TEXT		RW***	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Coordination of Benefits/Other Payers Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	<i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
339-6C	OTHER PAYER ID QUALIFIER		RW	<i>Imp Guide:</i> Required if Other Payer ID (340-7C) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
340-7C	OTHER PAYER ID		RW	<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Coordination of Benefits/Other Payers Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
356-NU	OTHER PAYER CARDHOLDER ID		RW	<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
992-MJ	OTHER PAYER GROUP ID		RW	<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
142-UV	OTHER PAYER PERSON CODE		RW	<i>Imp Guide:</i> Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number of the other payer to the receiver. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Coordination of Benefits/Other Payers Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	<i>Imp Guide:</i> Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		RW	<i>Imp Guide:</i> Required when other coverage is known which is after the Date of Service submitted. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		RW	<i>Imp Guide:</i> Required when other coverage is known which is after the Date of Service submitted. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Claim Billing/Claim Re-bill Rejected/Rejected Response

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Re-bill Rejected/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Response Transaction Header Segment		Claim Billing/Claim Re-bill Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	<ul style="list-style-type: none"> B1 Billing B3 Rebill 	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	R = Rejected	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01	M	01 – National Provider Identifier (NPI)
201-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Re-bill Rejected/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Message Segment Segment Identification (111-AM) = "20"		Claim Billing/Claim Re-bill Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Status Segment Questions	Check	Claim Billing/Claim Re-bill Rejected/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER			<i>Imp Guide:</i> Required if needed to identify the transaction. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW***	<i>Imp Guide:</i> Required if and only if 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. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

End of Response Claim Billing/Claim Re-bill (B1/B3) Payer Sheet

NCPDP Version D Claim Reversal

Request Claim Reversal Payer Sheet

****Start of Request Claim Reversal (B2) Payer Sheet****

General Information

Payer Name: Idaho Medicaid		
Plan Name/Group Name: IDMEDICAID	BIN: 014864	PCN: P043014864

Field Legend for Columns

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	R	The Field has been designated with the situation of “Required” for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	RW	“Required when.” The situations designated have qualifications for usage (“Required if x,” “Not required if y”).	Yes
NOT USED	NA	The Field is not used for the Segment in the designated Transaction. Not used are shaded for clarity for the Payer when creating the Template. For the actual Payer Template, not used fields must be deleted from the transaction (the row in the table removed).	No

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	Unlimited

Claim Reversal Transaction

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

Transaction Header Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used		

Transaction Header Segment		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN NUMBER	014864	M	
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2-Reversal	M	
104-A4	PROCESSOR CONTROL NUMBER	P043014864	M	
109-A9	TRANSACTION COUNT		M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01	M	01 = National Provider Identifier (NPI)
201-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
401-D1	DATE OF SERVICE	Format = CCYYMMDD	M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID		M	Assigned by Magellan Rx Management

Insurance Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Insurance Segment Segment Identification (111-AM) = "Ø4"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø2-C2	CARDHOLDER ID		M	Medicaid ID Number <patient specific>
3Ø1-C1	GROUP ID	IDMEDICAID	RW	<i>Imp Guide:</i> Required if needed to match the reversal to the original billing transaction. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Claim Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent	X	
This payer supports partial fills	X	
This payer does not support partial fills		

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	M	<i>Imp Guide:</i> For Transaction Code of "B2," in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	<ul style="list-style-type: none"> • ØØ = Not Specified • Ø3 = National Drug Code 	M	If reversal is for multi-ingredient prescription, the value must be ØØ.
4Ø7-D7	PRODUCT/SERVICE ID	<ul style="list-style-type: none"> • NDC – for non-compound claims • "Ø" – for compound claims 	M	

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
4Ø3-D3	FILL NUMBER	• Ø1 – 99	RW	<i>Imp Guide:</i> Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (4Ø2-D2) occur on the same day. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
3Ø8-C8	OTHER COVERAGE CODE		RW	<i>Imp Guide:</i> Required if needed by receiver to match the claim that is being reversed. <i>Payer Requirement:</i> For OCC = 2, 3, 4, or 8, the COB request segment is required.

Pricing Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent	X	

Pricing Segment Segment Identification (111-AM) = "11"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	<i>Imp Guide:</i> Required if this field could result in contractually agreed upon payment. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
43Ø-DU	GROSS AMOUNT DUE		RW	<i>Imp Guide:</i> Required if this field could result in contractually agreed upon payment. <i>Payer Requirement:</i> Co-pay amount when billing for co-pay only must match amount in Field # 48Ø-H9. For all other claims, Gross Amount

Pricing Segment Segment Identification (111-AM) = "11"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Due = Ingredient Cost submitted + Dispensing Fee Submitted.
Coordination of Benefits/Other Payments Segment Questions		Check	Claim Reversal If Situational, Payer Situation	
This Segment is always sent				
This Segment is situational		X		
Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
DUR/PPS Segment Questions		Check	Claim Reversal If Situational, Payer Situation	
This Segment is always sent				
This Segment is situational		X		
DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW***	<i>Imp Guide:</i> Required if DUR/PPS Segment is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
439-E4	REASON FOR SERVICE CODE		RW***	<i>Imp Guide:</i> Required if this field is needed to report drug utilization review outcome. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
44Ø-E5	PROFESSIONAL SERVICE CODE		RW***	<i>Imp Guide:</i> Required if this field is needed to report drug utilization review outcome. <i>Payer Requirement:</i> Submission of 00 is not allowed.
441-E6	RESULT OF SERVICE CODE		RW***	<i>Imp Guide:</i> Required if this field is needed to report drug utilization review outcome. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
474-8E	DUR/PPS LEVEL OF EFFORT		RW***	<i>Imp Guide:</i> Required if this field is needed to report drug utilization review outcome. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

End of Request Claim Reversal (B2) Payer Sheet

Response Claim Reversal Payer Sheet

Claim Reversal Accepted/Approved Response

****Start of Claim Reversal Response (B2) Payer Sheet****

General Information

Payer Name: Idaho Medicaid		
Plan Name/Group Name: IDMEDICAID	BIN: 014864	PCN: P043014864

Claim Reversal accepted/Approved Response

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

Response Transaction Header Segment Questions	Check	Claim Reversal Accepted/Approved If Situational, Payer Situation
This Segment is always sent	X	

Response Transaction Header Segment		Claim Reversal Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Reversal Accepted/Approved If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging.

Response Message Segment Segment Identification (111-AM) = "2Ø"		Claim Reversal Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
5Ø4-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Status Segment Questions	Check	Claim Reversal Accepted/Approved If Situational, Payer Situation
This Segment is always sent	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	<i>Imp Guide:</i> Required if needed to identify the transaction. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.	RW***	<i>Imp Guide:</i> Required if Approved Message Code (548-6F) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
548-6F	APPROVED MESSAGE CODE		RW***	<i>Imp Guide:</i> Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW***	<i>Imp Guide:</i> Required if and only if 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. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Claim Segment Questions	Check	Claim Reversal Accepted/Approved If Situational, Payer Situation
This Segment is always sent	X	

Response Claim Segment Segment Identification (111-AM) = "22"		Claim Reversal Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	M	<i>Imp Guide:</i> For Transaction Code of "B2," in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response Pricing Segment Questions	Check	Claim Reversal Accepted/Approved If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Reversal Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
521-FL	INCENTIVE AMOUNT PAID		RW	<i>Imp Guide:</i> Required if this field is reporting a contractually agreed upon payment. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
509-F9	TOTAL AMOUNT PAID		RW	<i>Imp Guide:</i> Required if any other payment fields sent by the sender. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Claim Reversal Accepted/Rejected Response

Response Transaction Header Segment Questions	Check	Claim Reversal Accepted/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Response Transaction Header Segment		Claim Reversal Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01	M	01 - National Provider Identifier (NPI)
201-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Reversal Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Message Segment Identification (111-AM) = "20"		Claim Reversal Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Status Segment Questions	Check	Claim Reversal Accepted/Rejected If Situational, Payer Situation
-----------------------------------	-------	--

This Segment is always sent	X	
-----------------------------	---	--

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW***	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW***	<i>Imp Guide:</i> Required if and only if 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. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Claim Segment Questions	Check	Claim Reversal Accepted/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Response Claim Segment Segment Identification (111-AM) = "22"		Claim Reversal Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	M	<i>Imp Guide:</i> For Transaction Code of "B2," in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).

Response Claim Segment Segment Identification (111-AM) = "22"		Claim Reversal Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Claim Reversal Rejected/Rejected Response

Response Transaction Header Segment Questions	Check	Claim Reversal Rejected/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Response Transaction Header Segment		Claim Reversal Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01	M	01 - National Provider Identifier (NPI)
201-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Reversal Rejected/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Message Segment Identification (111-AM) = "20"		Claim Reversal Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

Response Status Segment Questions	Check	Claim Reversal Rejected/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW***	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW***	<i>Imp Guide:</i> Required if and only if 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. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Same as <i>Imp Guide.</i>

End of Claim Reversal (B2) Response Payer Sheet

Revision History

Date	Name	Comments
01/01/2012	Implementation team	Initial creation
07/24/2020	Steven Giera	Added quantity prescribed field (# 460-ET) required for Schedule II drugs in Claim Segment 07
	Documentation Management team	Rebranded; reformatted; updated and standardized naming conventions; and added Revision History table