



## NCPDP Version D.0 Commercial Payer Sheet

### GENERAL INFORMATION

Payer Name: <b>Preferred Medical</b>		Date: <b>02/27/2023</b>
Plan Name/Group Name: <b>Preferred Medical</b>		BIN: <b>023237</b> PCN: <b>PMN</b>
Processor: <b>ProCare Rx</b>		
Effective as of: <b>02/23/2023</b>		NCPDP Telecommunication Standard Version/Release #: <b>D.0</b>
NCPDP Data Dictionary Version Date: <b>07/2007</b>		NCPDP External Code List Version Date: <b>10/2018</b>
Contact/Information Source: <b>Provider Manuals available at <a href="https://Pharmacy.ProCareRx.com">https://Pharmacy.ProCareRx.com</a></b> <b>General website <a href="http://www.procarerx.com">www.procarerx.com</a></b>		
Certification: <b>Not Required</b>		
Provider Relations Help Desk Info: <b>888.586.4650 Option 1</b>		
Other versions supported: <b>NONE</b>		

### OTHER TRANSACTIONS SUPPORTED

Transaction Code	Transaction Name
<b>B1</b>	<b>Claim Billing</b>
<b>B2</b>	<b>Claim Reversal</b>

### FIELD LEGEND FOR COLUMNS

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

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

### CLAIM BILLING/CLAIM REBILL TRANSACTION

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	<b>X</b>	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued		
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	<b>X</b>	

Field #	Transaction Header Segment <i>NCPDP Field Name</i>	Value	Payer Usage	Claim Billing/Claim Rebill <i>Payer Situation</i>
101-A1	BIN NUMBER	<b>023237</b>	M	<b>BIN for Plan</b>
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1	M	Claim Billing
104-A4	PROCESSOR CONTROL NUMBER	PMN	M	
109-A9	TRANSACTION COUNT		M	
202-B2	SERVICE PROVIDER ID QUALIFIER	<b>01 = National Provider ID</b>	M	
201-B1	SERVICE PROVIDER ID	<b>NPI</b>	M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	<b>Blank fill</b>	M	<b>Blank fill</b>

Insurance Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	<b>X</b>	

Field #	Insurance Segment Segment Identification (111-AM) = "04"	Value	Payer Usage	Claim Billing/Claim Rebill <i>Payer Situation</i>
302-C2	CARDHOLDER ID		M	<b>Number provided on card</b>

	<b>Insurance Segment Segment Identification (111-AM) = "Ø4"</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø3-C3	PERSON CODE		RW	<i>Imp Guide:</i> Required if needed to uniquely identify the family members within the Cardholder ID.  <i>Payer Requirement:</i> <b>Required when provided on the ID card.</b>
3Ø6-C6	PATIENT RELATIONSHIP CODE		RW	<i>Imp Guide:</i> Required if needed to uniquely identify the relationship of the Patient to the Cardholder.  <i>Payer Requirement:</i> <b>Required.</b>
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE		RW	<i>Imp Guide:</i> Required if needed for receiver inquiry validation and/or determination, when eligibility is not maintained at the dependent level. Required in special situations as defined by the code to clarify the eligibility of an individual, which may extend coverage.
3Ø1-C1	GROUP ID		RW	<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> <b>Required.</b>

<b>Patient Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill If Situational, Payer Situation</b>
This Segment is always sent	<b>X</b>	
This Segment is situational		

	<b>Patient Segment Segment Identification (111-AM) = "Ø1"</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE		R	
31Ø-CA	PATIENT FIRST NAME		RW	<i>Imp Guide:</i> Required when the patient has a first name.  <i>Payer Requirement:</i> <b>Required</b>
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		R	<i>Imp Guide:</i> Optional.
323-CN	PATIENT CITY ADDRESS		RW	<i>Imp Guide:</i> Optional. <b>Provide information when available</b>
324-CO	PATIENT STATE / PROVINCE ADDRESS		RW	<i>Imp Guide:</i> Optional. <b>Provide information when available</b>
325-CP	PATIENT ZIP/POSTAL ZONE		RW	<i>Imp Guide:</i> Optional. <b>Provide information when available</b>
326-CQ	PATIENT PHONE NUMBER		RW	<i>Imp Guide:</i> Optional. <b>Provide information when available</b>
3Ø7-C7	PLACE OF SERVICE		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> <b>Required for values listed.</b>

	Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
35Ø-HN	PATIENT E-MAIL ADDRESS		RW	<i>Imp Guide:</i> May be submitted for the receiver to relay patient health care communications via the Internet when provided by the patient.
384-4X	PATIENT RESIDENCE	)	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i>

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	
This payer does <i>not</i> support partial fills	X	

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	Ø1 = Rx Billing	M	Claim Billing <i>Imp Guide:</i> For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing)
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code (NDC)	M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	Ø1 = Not a Compound Ø2 = Compound	R	See Compound Segment for support of multi-ingredient compounds
4Ø8-D8	DISPENSE AS WRITTEN (DAW/PRODUCT SELECTION CODE)		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED		RW	<i>Imp Guide:</i> Required if necessary for plan benefit administration.
419-DJ	PRESCRIPTION ORIGIN CODE		RW	<i>Imp Guide:</i> Required if necessary for plan benefit administration.
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Submission Clarification Code (42Ø-DK) is used.
42Ø-DK	SUBMISSION CLARIFICATION CODE		RW	<i>Imp Guide:</i> Required if clarification is needed and value submitted is greater than zero (Ø).  <i>Payer Requirement:</i> Required when further explanation is needed for overrides.

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
460-ET	QUANTITY PRESCRIBED		RW	<i>Imp Guide:</i> Required when the transmission is for a Schedule II drug as defined in 21 CFR 1308.12 and per CMS-0055-F (Compliance Date 9/21/2020. Refer to the Version D.0 Editorial Document).  <i>Payer Requirement: (any unique payer requirement(s))</i>
3Ø8-C8	OTHER COVERAGE CODE	COB not accepted on this BIN	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: Only used in COB processing.</i>
418-DI	LEVEL OF SERVICE		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.
461-EU	PRIOR AUTHORIZATION TYPE CODE	1 = Prior Authorization	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement: Required when value 1 Prior Authorization Number Submitted field is used.</i>
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: Required when 1 in field 461-EU.</i>
995-E2	ROUTE OF ADMINISTRATION		RW	<i>Imp Guide:</i> Required if specified in trading partner agreement.  <i>Payer Requirement: Required when Compound Code (4Ø6-D6) = 2 (compound).</i>
147-U7	PHARMACY SERVICE TYPE		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.

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

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
4Ø9-D9	INGREDIENT COST SUBMITTED		R	

	<b>Pricing Segment Segment Identification (111-AM) = "11"</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
412-DC	DISPENSING FEE SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
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.
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		RW	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted (48Ø-H9) is used.
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		RW	<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used.  Required if this field could result in different pricing.  Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		RW	<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used.  Required if this field could result in different pricing.  Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).
426-DQ	USUAL AND CUSTOMARY CHARGE		RW	<i>Imp Guide:</i> Required if needed per trading partner agreement.  <i>Payer Requirement: Required</i>
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		RW	<i>Imp Guide:</i> Required if needed for receiver claim/encounter adjudication.

Pharmacy Provider Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

	Pharmacy Provider Segment Segment Identification (111-AM) = "Ø2"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
465-EY	PROVIDER ID QUALIFIER	02=State License ID	RW	Imp Guide: Required if Provider ID (444-E9) is used.  Payer Requirement: Required
444-E9	PROVIDER ID	Pharmacist License Number required for Florida	RW	Imp Guide: Required if necessary for state/federal/regulatory agency programs.  Required if necessary to identify the individual responsible for dispensing of the prescription.  Required if needed for reconciliation of encounter-reported data or encounter reporting.  Payer Requirement: Required for Florida

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

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = NPI	R	Imp Guide: Required if Prescriber ID (411-DB) is used.  Payer Requirement: Required
411-DB	PRESCRIBER ID		R	Imp Guide: Required if this field could result in different coverage or patient financial responsibility.  Required if necessary for state/federal/regulatory agency programs.  Payer Requirement: Required
427-DR	PRESCRIBER LAST NAME		RW	Imp Guide: Required when the Prescriber ID (411-DB) is not known.  Required if needed for Prescriber ID (411-DB) validation/clarification.

Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required when Compound Code (406-D6) = 2 (compound).

	Compound Segment Segment Identification (111-AM) = "10"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum of 25 ingredients.	M	Payer Requirement: Maximum of 10 ingredients.
488-RE	COMPOUND PRODUCT ID QUALIFIER	03 = National Drug Code	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		RW	Imp Guide: Required if needed for receiver claim determination when multiple products are billed.  Payer Requirement: Required for each ingredient.

1.

## CLAIM BILLING ACCEPTED/PAID (OR DUPLICATE OF PAID) RESPONSE

### GENERAL INFORMATION

Payer Name: <b>Preferred Medical</b>	Date: <b>10/01/2020</b>	
Plan Name/Group Name: <b>Preferred Medical</b>	BIN: <b>023237</b>	PCN: <b>PMN</b>

### CLAIM BILLING/CLAIM REBILL PAID (OR DUPLICATE OF PAID) RESPONSE

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent	<b>X</b>	

	Response Transaction Header Segment			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B1	M	Claim Billing
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 Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent		
This Segment is situational	<b>X</b>	<i>Provide general information when used for transmission-level messaging.</i>

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

Response Insurance Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent	<b>X</b>	

	Response Insurance Segment Segment Identification (111-AM) = “25”			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
301-C1	GROUP ID		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.
524-FO	PLAN ID		RW	<i>Imp Guide:</i> Optional.



<b>Response Status Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	<b>X</b>	

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
503-F3	AUTHORIZATION NUMBER		RW	<i>Imp Guide:</i> Required if needed to identify the transaction.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.

<b>Response Claim Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	<b>X</b>	

	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
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	

<b>Response Pricing Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	<b>X</b>	

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID		RW	
557-AV	TAX EXEMPT INDICATOR			<i>Imp Guide:</i> Required if the sender (health plan) and/or patient is tax exempt and exemption applies to this billing.
558-AW	FLAT SALES TAX AMOUNT PAID			<i>Imp Guide:</i> Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (Ø) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement.

	Response Pricing Segment Segment Identification (111-AM) = "23"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
559-AX	PERCENTAGE SALES TAX AMOUNT PAID			<p><i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.</p> <p>Required if Percentage Sales Tax Amount Submitted (482-GE) is greater than zero (Ø).</p> <p>Required if Percentage Sales Tax Rate Paid (56Ø-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used.</p>
56Ø-AY	PERCENTAGE SALES TAX RATE PAID			<p><i>Imp Guide:</i> Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).</p>
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	RW	<p><i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used.</p> <p><i>Payer Requirement: Will be returned when submission includes Other Amount Claimed Submitted.</i></p>
564-J3	OTHER AMOUNT PAID QUALIFIER		RW	<p><i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used.</p> <p><i>Payer Requirement: Will be returned when submission includes Other Amount Claimed Submitted.</i></p>
565-J4	OTHER AMOUNT PAID		RW	<p><i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.</p> <p>Required if Other Amount Claimed Submitted (48Ø-H9) is greater than zero (Ø).</p> <p><i>Payer Requirement: Will be returned when submission includes Other Amount Claimed Submitted.</i></p>
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	<p><i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.</p> <p>Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.</p> <p><i>Payer Requirement: Same as Imp Guide.</i></p>
5Ø9-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	<p>3 = Ingredient Cost Reduced to AWP Less X% Pricing</p> <p>4 = Usual &amp; Customary Paid as Submitted</p> <p>6 = MAC Pricing Ingredient Cost Paid</p> <p>15 = Patient Pay Amount</p>	RW	<p><i>Imp Guide:</i> Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø).</p> <p>Required if Basis of Cost Determination (432-DN) is submitted on billing.</p> <p><i>Payer Requirement: Same as Imp Guide.</i></p>

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
523-FN	AMOUNT ATTRIBUTED TO SALES TAX		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes sales tax that is the financial responsibility of the member but is not also included in any of the other fields that add up to Patient Pay Amount.
513-FD	REMAINING DEDUCTIBLE AMOUNT		RW	<i>Imp Guide:</i> Provided for informational purposes only.
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes deductible
518-FI	AMOUNT OF COPAY		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes copay as patient financial responsibility.
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.

<b>Response DUR/PPS Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation</b>
This Segment is always sent		
This Segment is situational	<b>X</b>	When DUR information applicable

	<b>Response DUR/PPS Segment Segment Identification (111-AM) = "24"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
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.
439-E4	REASON FOR SERVICE CODE		RW	<i>Imp Guide:</i> Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
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.
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.

	<b>Response DUR/PPS Segment Segment Identification (111-AM) = "24"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
532-FW	DATABASE INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.

## 2.

## CLAIM BILLING ACCEPTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Rejected Payer Situation
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B1	M	Claim Billing
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 Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Provided when additional message text</i>

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) Payer Situation
504-F4	MESSAGE			<i>Imp Guide:</i> Required if text is needed for clarification or detail.

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Rejected Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
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.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Billing/Claim Rebill – Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
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	

<b>Response DUR/PPS Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation</b>
This Segment is always sent		
This Segment is situational	<b>X</b>	<b>When DUR information applicable</b>

	<b>Response DUR/PPS Segment Segment Identification (111-AM) = "24"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.		<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE			<i>Imp Guide:</i> Required if utilization conflict is detected.
529-FT	OTHER PHARMACY INDICATOR			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
530-FU	PREVIOUS DATE OF FILL			<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.
531-FV	QUANTITY OF PREVIOUS FILL			<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.
532-FW	DATABASE INDICATOR			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.

<b>Response Coordination of Benefits/Other Payers Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation</b>
This Segment is always sent		
This Segment is situational	<b>X</b>	<b>When other payer information exists</b>

	<b>Response Coordination of Benefits/Other Payers Segment Identification (111-AM) = "28"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE	Ø1 = Primary	M	
339-6C	OTHER PAYER ID QUALIFIER	Ø3 - BIN		<i>Imp Guide:</i> Required if Other Payer ID (34Ø-7C) is used.
34Ø-7C	OTHER PAYER ID			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits.
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits.
356-NU	OTHER PAYER CARDHOLDER ID			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits.
992-MJ	OTHER PAYER GROUP ID			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits.
142-UV	OTHER PAYER PERSON CODE			<i>Imp Guide:</i> Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer.

### 3.

## CLAIM BILLING REJECTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

Response Transaction Header Segment				Claim Billing/Claim Rebill – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1	M	Claim Billing
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	R = Rejected	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 Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Provide general information when used for transmission-level messaging.</i>

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

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

Response Status Segment Segment Identification (111-AM) = “21”				Claim Billing/Claim Rebill – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
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.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.

Response Insurance Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i>
This Segment is always sent	X	



	<b>Response Insurance Segment Segment Identification (111-AM) = "25"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
524-FO	PLAN ID			<p><i>Imp Guide:</i> Required if needed to identify the actual plan parameters, benefit, or coverage criteria, when available.</p> <p>Required to identify the actual plan ID that was used when multiple group coverages exist.</p> <p>Required if needed to contain the actual plan ID if unknown to the receiver.</p>

# 4.

# CLAIM REVERSAL REQUEST

## GENERAL INFORMATION

Payer Name: <b>Preferred Medical</b>	Date: <b>02/23/2023</b>
Plan Name/Group Name: <b>Preferred Medical</b>	BIN: <b>023237</b> PCN: <b>PMN</b>

## FIELD LEGEND FOR COLUMNS

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

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	<b>90 days</b>

## CLAIM REVERSAL TRANSACTION

Transaction Header Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent	<b>X</b>	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	<b>X</b>	

Field #	Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Reversal Payer Situation
1Ø1-A1	BIN NUMBER	<b>023237</b>	M	<b>BIN for plan</b>
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	Claim Reversal
1Ø4-A4	PROCESSOR CONTROL NUMBER	<b>PMN</b>	M	
1Ø9-A9	TRANSACTION COUNT		M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	<b>Ø1 = National Provider ID</b>	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	<b>Blank fill</b>	M	<b>Blank fill</b>

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

Field #	Insurance Segment Segment Identification (111-AM) = "Ø4" NCPDP Field Name	Value	Payer Usage	Claim Reversal Payer Situation
3Ø2-C2	CARDHOLDER ID		M	<b>Member's ID as shown on card.</b>
3Ø1-C1	GROUP ID		RW	<i>Imp Guide:</i> Required if needed to match the reversal to the original billing transaction.  <i>Payer Requirement:</i> <b>Required.</b>

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

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 = Rx Billing	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	
Ø3-D3	FILL NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø1 = Universal Product Code (UPC) Ø3 = National Drug Code (NDC)	M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
4Ø3-D3	FILL NUMBER		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 Imp Guide.
3Ø8-C8	OTHER COVERAGE CODE	Same values as original Claim Billing	RW	<i>Imp Guide:</i> Required if needed by receiver to match the claim that is being reversed.  <i>Payer Requirement:</i> Required when reversing a secondary or subsequent claim.

## 5.

## CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

## GENERAL INFORMATION

Payer Name: Preferred Medical	Date: 02/23/2023
Plan Name/Group Name: Preferred Medical	BIN: 023237 PCN: PMN

## CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

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

Field #	NCPDP Field Name	Value	Payer Usage	Claim Reversal – Accepted/Approved Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	Claim Reversal
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 Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Provide general information when used for transmission-level messaging.</i>

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) Payer Situation
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> (any unique payer requirement(s))

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

Field #	NCPDP Field Name	Value	Payer Usage	Claim Reversal – Accepted/Approved Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	A = Approved S = Duplicate of Approved	M	
503-F3	AUTHORIZATION NUMBER		RW	<i>Imp Guide:</i> Required if needed to identify the transaction.  <i>Payer Requirement:</i> Will contain the trace back number of the reversal.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Will be returned.

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

	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Reversal – Accepted/Approved</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	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	

## 6.

## CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

## CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

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

Field #	NCPDP Field Name	Value	Payer Usage	Claim Reversal – Accepted/Rejected Payer Situation
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B2	M	Claim Reversal
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 Ø1 = National Provider ID	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/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Will be returned on rejected claims when the error is at transmission-level.

Field #	NCPDP Field Name	Value	Payer Usage	Claim Reversal – Accepted/Rejected Payer Situation
504-F4	MESSAGE		RW	Imp Guide: Required if text is needed for clarification or detail.  Payer Requirement: Will be returned when text information needs to be sent.

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

Field #	NCPDP Field Name	Value	Payer Usage	Claim Reversal – Accepted/Rejected Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Imp Guide: Required when additional text is needed for clarification or detail.  Payer Requirement: Will be returned.

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

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

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

## 7.

## CLAIM REVERSAL REJECTED/REJECTED RESPONSE

## CLAIM REVERSAL REJECTED/REJECTED RESPONSE

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

Field #	NCPDP Field Name	Value	Payer Usage	Claim Reversal – Rejected/Rejected Payer Situation
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B2	M	Claim Reversal
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	R = Rejected	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 – Rejected/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Will be returned on rejected claims when the error is at transmission-level.

Field #	NCPDP Field Name	Value	Payer Usage	Claim Reversal – Rejected/Rejected Payer Situation
504-F4	MESSAGE		RW	Imp Guide: Required if text is needed for clarification or detail.  Payer Requirement: Will be returned when text information needs to be sent.

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

Field #	NCPDP Field Name	Value	Payer Usage	Claim Reversal – Rejected/Rejected 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	Imp Guide: Required if a repeating field is in error, to identify repeating field occurrence.  Payer Requirement: Same as Imp Guide.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Imp Guide: Required if Additional Message Information (526-FQ) is used.  Payer Requirement: Maximum count of 2 will be returned.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Used for second line of free form text with no pre-defined structure.	RW	Imp Guide: Required if Additional Message Information (526-FQ) is used.  Payer Requirement: Only qualifier values cited will be returned.



	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Reversal – Rejected/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</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> <b>Will be returned.</b>
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used.  <i>Payer Requirement:</i> <b>Will be returned.</b>
55Ø-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> <b>Will be returned.</b>