**Change Healthcare**

**NCPDP Version D.0 Payer Sheet**

**\*\*\*Commercial\*\*\***

***Claim Billing/Claim Rebill (B1/B3)***

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| **\*\* Start of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template\*\*** |

**GENERAL INFORMATION**

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| --- | --- | --- |
| Payer Name: Change HealthCare | Date: 04/04/2018 | |
| Plan Name/Group Name: Change Healthcare Commercial | BIN: 004682 | PCN: CN or Varies by Plan refer to Card |
| Plan Name/Group Name: Change Healthcare Commercial | BIN: 600426 | PCN: 54 or Varies by Plan refer to Card |
|  |  |  |
| Plan Name/Group Name: RX.Com | BIN: 014947 | PCN: PBC or RXC |
| Plan Name:/Group Name: Rx.Com | BIN: 015251 | PCN: PRX2000 |
| Plan Name/Group Name: MedAdvance | BIN: 022162 | PCN: NVH |
| Plan Name/Group Name: Clutch Health PBS | BIN: 022220 | PCN: CLP |
| Plan Name/Group Name: CareGuard | BIN: 022584 | PCN: AF |
|  |  |  |
| Processor: Change Healthcare |  |  |
| Effective as of: 04/04/2018 |  |  |
| NCPDP Data Dictionary Version Date: October 2016 | NCPDP External Code List Version Date: October 2016 |  |
| Contact/Information Source: Pharmacy Helpdesk 800-433-4893 E-mail: [SelectRx\_Help\_Desk@changehealthcare.com](mailto:SelectRx_Help_Desk@changehealthcare.com) | | |  |
| Certification Testing Window: Certification Not Required |  | |
| Provider Relations Help Desk Info: Provider.relations@changehealthcare.com |  | |
| Other versions supported: Only D.Ø | | |
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**OTHER TRANSACTIONS SUPPORTED**

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

|  |  |
| --- | --- |
| **Transaction Code** | **Transaction Name** |
|  |  |
|  |  |

**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 |

**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**

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

|  |  |  |
| --- | --- | --- |
| **Transaction Header Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  If Situational, *Payer Situation* |
| This Segment is always sent | X |  |
| 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 |  |  |

|  | **Transaction Header Segment** |  |  | **Claim Billing/Claim Rebill** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 1Ø1-A1 | BIN Number | See general information above | M |  |
| 1Ø2-A2 | Version/Release Number | DØ | M |  |
| 1Ø3-A3 | Transaction Code | B1, B3 | M |  |
| 1Ø4-A4 | Processor Control Number | See above | M | Varies by plan |
| 1Ø9-A9 | Transaction Count | 1-4 | M |  |
| 2Ø2-B2 | Service Provider ID Qualifier | 01 - NPI | M |  |
| 2Ø1-B1 | Service Provider ID | NPI | M |  |
| 4Ø1-D1 | Date of Service |  | M |  |
| 11Ø-AK | Software Vendor/Certification ID | blank | M |  |

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| --- | --- | --- |
| **Insurance Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  If Situational, *Payer Situation* |
| This Segment is always sent | X |  |

|  | **Insurance Segment**  **Segment Identification (111-AM) = “Ø4”** |  |  | **Claim Billing/Claim Rebill** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 3Ø2-C2 | CARDHOLDER ID |  | M |  |
| 3Ø1-C1 | GROUP ID | Varies refer to Patient ID card for Group No. | R | *Imp Guide:* Required if necessary for state/federal/regulatory agency programs.  *Group Id is required. Claim will reject if not submitted* |
| 3Ø3-C3 | PERSON CODE |  | R | *Imp Guide:* Required if needed to uniquely identify the family members within the Cardholder ID.  *Payer Requirement: Same as Implementation guide* |
| 3Ø6-C6 | PATIENT RELATIONSHIP CODE |  | R | *Imp Guide:* Required if needed to uniquely identify the relationship of the Patient to the Cardholder.  *Payer Requirement: Required to uniquely identify the relationship of the Patient to the Cardholder. Claim will reject if missing or Invalid* |
|  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Patient Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  If Situational, *Payer Situation* |
| This Segment is always sent | x |  |
| This Segment is situational |  |  |

|  | **Patient Segment**  **Segment Identification (111-AM) = “Ø1”** |  |  | **Claim Billing/Claim Rebill** |
| --- | --- | --- | --- | --- |
| *Field* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 3Ø4-C4 | DATE OF BIRTH |  | R | *Required to uniquely Identify a Patient. Claim will reject if missing or invalid* |
| 3Ø5-C5 | PATIENT GENDER CODE |  | R | *Required to uniquely Identify a Patient. Claim will reject if missing or invalid* |
| 31Ø-CA | PATIENT FIRST NAME |  | R | *Required to uniquely Identify a Patient. Claim will reject if missing or invalid* |
| 311-CB | PATIENT LAST NAME |  | R | *Required to uniquely Identify a Patient. Claim will reject if missing or invalid* |

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

|  | **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 | | 1 = Rx Billing | | | M | | *Imp Guide:* For Transaction Code of “B1”, in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing). |
| 4Ø2-D2 | Prescription/Service Reference Number | |  | | | M | |  |
| 436-E1 | Product/Service ID Qualifier | | 03 - NDC | | | M | | 00 if Compound Code (406-D6) = 2 |
| 4Ø7-D7 | Product/Service ID | | 11-digit NDC | | | M | | 0 if Compound Code (406-D6) = 2 |
| 442-E7 | QUANTITY DISPENSED | | Format 9(7)V999 | | | R | | *Required to Pay a claim will reject if missing or invalid* |
| 4Ø3-D3 | FILL NUMBER | | New = 00 must be sent | | | R | | *Required to Pay a claim will reject if missing or invalid* |
| 4Ø5-D5 | DAYS SUPPLY | |  | | | R | | *Required to Pay a claim will reject if missing or invalid* |
| 4Ø6-D6 | COMPOUND CODE | | 1 = Not a compound  2 = Compound | | | R | | Refer to Compound Segment when Compound Code (406-D6) = 2 |
| 4Ø8-D8 | DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE | |  | | | R | | *Required to Pay a claim will reject if missing or invalid* |
| 414-DE | DATE PRESCRIPTION WRITTEN | |  | | | R | | *Required to Pay a claim will reject if missing or invalid* |
| 415-DF | NUMBER OF REFILLS AUTHORIZED | |  | | | R | | *Imp Guide: Required if necessary, for plan benefit administration.*  *Payer Requirement: Should be 0 when filling Schedule II Drug* |
| 419-DJ | PRESCRIPTION ORIGIN CODE | |  | | | R | | *Imp Guide:* Required if necessary for plan benefit administration.  *Payer Requirement: Same as Implementation guide* |
| 354-NX | SUBMISSION CLARIFICATION CODE COUNT | | Maximum count of 3. | | | RW | | *Imp Guide:* Required if Submission Clarification Code (42Ø-DK) is used.  *Payer Requirement: Same as implementation guide* |
| 42Ø-DK | SUBMISSION CLARIFICATION CODE | |  | | | RW | | *Imp Guide:* 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 – indicates the quantity dispensed is the remainder billed to a subsequent payer when Medicare Part A expires. Used only in long-term care settings) for individual unit of use medications.  *Payer Requirement: Same as Implementation guide* |
| 46Ø-ET | QUANTITY PRESCRIBED | |  | | | RW | | *Imp Guide:* Required for all drugs dispensed as Schedule II.  *Payer Requirement: Must submit quantity Prescribed and Quantity dispensed Number of Refills Authorized should be 0* |
| 3Ø8-C8 | OTHER COVERAGE CODE | | 0 = Not specified by patient  1 = No other coverage  3 = Other coverage exist – claim not covered\*  8 = Claim is billing for patient financial responsibility only\* | | | RW | | *Imp Guide:* 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.  *Payer Requirement: Same as Implementation guide*  *\*Requires COB Segment to be sent* |
| 429-DT | SPECIAL PACKAGING INDICATOR | |  | | |  | | *Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility.  *Payer Requirement:* (any unique payer requirement(s)) |
| 453-EJ | | ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER | |  | | |  | *Imp Guide:* Required if Originally Prescribed Product/Service Code (455-EA) is used.  *Payer Requirement:* (any unique payer requirement(s)) | |
| 445-EA | | ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE | |  | | |  | *Imp Guide:* Required if the receiver requests association to a therapeutic, or a preferred product substitution, or when a DUR alert has been resolved by changing medications, or an alternative service than what was originally prescribed.  *Payer Requirement:* (any unique payer requirement(s)) | |
| 446-EB | | ORIGINALLY PRESCRIBED QUANTITY | |  | | |  | *Imp Guide:* Required if the receiver requests reporting for quantity changes due to a therapeutic substitution that has occurred or a preferred product/service substitution that has occurred, or when a DUR alert has been resolved by changing quantities.  *Payer Requirement:* (any unique payer requirement(s)) | |
| 454-EK | | SCHEDULED PRESCRIPTION ID NUMBER | |  | | |  | *Imp Guide:* Required if necessary for state/federal/regulatory agency programs.  *Payer Requirement:* | |
| 6ØØ-28 | | UNIT OF MEASURE | |  | | |  | *Imp Guide:* Required if necessary for state/federal/regulatory agency programs.  Required if this field could result in different coverage, pricing, or patient financial responsibility.  *Payer Requirement:* | |
| 418-DI | | LEVEL OF SERVICE | |  | | |  | *Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility.  *Payer Requirement:* | |
| 461-EU | | PRIOR AUTHORIZATION TYPE CODE | |  | | |  | *Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility.  *Payer Requirement:* | |
| 995-E2 | | ROUTE OF ADMINISTRATION | |  | | | RW | *Imp Guide:* Required if specified in trading partner agreement.  *Payer Requirement: When compound Code (406 – D6) = 2* | |
|  | |  | |  | | |  |  | |
| **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 |  |
| 412-DC | DISPENSING FEE SUBMITTED |  | R | *Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. |
| 433-DX | PATIENT PAID AMOUNT SUBMITTED |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. |
| 478-H7 | OTHER AMOUNT CLAIMED SUBMITTED COUNT | Maximum count of 3. | RW | *Imp Guide:* Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.  *Payer Requirement: Same as Implementation guide* |
| 479-H8 | OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER |  | RW | *Imp Guide:* Required if Other Amount Claimed Submitted (48Ø-H9) is used.  *Payer Requirement: Same as Implementation guide* |
| 48Ø-H9 | OTHER AMOUNT CLAIMED SUBMITTED |  | RW | *Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.  *Payer Requirement: Same as Implementation guide* |
| 481-HA | FLAT SALES TAX AMOUNT SUBMITTED |  | RW | *Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.  *Payer Requirement: Same as Implementation guide* |
| 482-GE | PERCENTAGE SALES TAX AMOUNT SUBMITTED |  | RW | *Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.  *Payer Requirement: Same as Implementation guide* |
| 483-HE | PERCENTAGE SALES TAX RATE SUBMITTED |  | RW | *Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used.  Required if this field could result in different pricing.  Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).  *Payer Requirement: Same as Implementation guide* |
| 484-JE | PERCENTAGE SALES TAX BASIS SUBMITTED |  | RW | *Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used.  Required if this field could result in different pricing.  Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).  *Payer Requirement: Same as Implementation guide* |
| 426-DQ | USUAL AND CUSTOMARY CHARGE |  | R | *Imp Guide:* Required if needed per trading partner agreement. |
| 43Ø-DU | GROSS AMOUNT DUE |  | R |  |
| 423-DN | BASIS OF COST DETERMINATION |  | R | *Imp Guide:* Required if needed for receiver claim/encounter adjudication. |

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| **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 | 01 = NPI  12 = DEA | R | *Imp Guide:* Required if Prescriber ID (411-DB) is used. |
| 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. |
| 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.  *Payer Requirement: Required when submitting DEA* |
| 364-2J | PRESCRIBER FIRST NAME |  | RW | *Imp Guide:* Required if needed to assist in identifying the prescriber.  Required if necessary for state/federal/regulatory agency programs.  *Payer Requirement:* Required When submitting DEA |
| 365-2K | PRESCRIBER STREET ADDRESS |  | RW | *Imp Guide:* Required if needed to assist in identifying the prescriber.  Required if necessary for state/federal/regulatory agency programs.  *Payer Requirement: Required when submitting DEA* |
| 366-2M | PRESCRIBER CITY ADDRESS |  | RW | *Imp Guide:* Required if needed to assist in identifying the prescriber.  Required if necessary for state/federal/regulatory agency programs.  *Payer Requirement: Required when submitting DEA* |
| 367-2N | PRESCRIBER STATE/PROVINCE ADDRESS |  | RW | *Imp Guide:* Required if needed to assist in identifying the prescriber.  Required if necessary for state/federal/regulatory agency programs.  *Payer Requirement: Required when submitting DEA* |
| 368-2P | PRESCRIBER ZIP/POSTAL ZONE |  | RW | *Imp Guide:* Required if needed to assist in identifying the prescriber.  Required if necessary for state/federal/regulatory agency programs.  *Payer Requirement: Required When submitting DEA* |

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| --- | --- | --- |
| **Coordination of Benefits/Other Payments Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  If Situational, *Payer Situation* |
| This Segment is always sent |  |  |
| This Segment is situational | X | Required only for secondary, tertiary etc.. OPPRA |
|  |  |  |
| Scenario 1 - Other Payer Amount Paid Repetitions Only | X | Required only for secondary, Tertiary, etc. claims Other Coverage Code (308-C8) = 3, 8 |

|  | **Coordination of Benefits/Other Payments Segment**  **Segment Identification (111-AM) = “Ø5”** |  |  | **Claim Billing/Claim Rebill**  Scenario 2- Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only |
| --- | --- | --- | --- | --- |
| *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 |  |
| 339-6C | OTHER PAYER ID QUALIFIER | 03 - BIN |  | *Imp Guide:* Required if Other Payer ID (34Ø-7C) is used. |
| 34Ø-7C | OTHER PAYER ID | BIN |  | *Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication. |
| 443-E8 | OTHER PAYER DATE |  |  | *Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. |
| 471-5E | OTHER PAYER REJECT COUNT | Maximum count of 5. |  | *Imp Guide:* Required if Other Payer Reject Code (472-6E) is used. |
| 472-6E | OTHER PAYER REJECT CODE |  |  | *Imp Guide:* Required when the other payer has denied the payment for the billing. |
| 353-NR | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT | Maximum count of 25. |  | *Imp Guide:* Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. |
| 351-NP | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER |  |  | *Imp Guide:* Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. |
| 352-NQ | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT |  |  | *Imp Guide:* 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.. |

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| --- | --- | --- |
| **DUR/PPS Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  If Situational, *Payer Situation* |
| This Segment is always sent |  |  |
| This Segment is situational | X | For use to define professional services or override clinical edits |

|  | **DUR/PPS Segment**  **Segment Identification (111-AM) = “Ø8”** |  |  | **Claim Billing/Claim Rebill** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 473-7E | DUR/PPS CODE COUNTER | Maximum of 9 occurrences. | R | *Imp Guide:* Required if DUR/PPS Segment is used. |
| 439-E4 | REASON FOR SERVICE CODE |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service. |
| 44Ø-E5 | PROFESSIONAL SERVICE CODE |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service. |
| 441-E6 | RESULT OF SERVICE CODE |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service. |
| 474-8E | DUR/PPS LEVEL OF EFFORT |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service. |
| 475-J9 | DUR CO-AGENT ID QUALIFIER |  | R | *Imp Guide:* Required if DUR Co-Agent ID (476-H6) is used. |
| 476-H6 | DUR CO-AGENT ID |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service. |

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| --- | --- | --- |
| **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 Segment**  **Segment Identification (111-AM) = “1Ø”** |  |  | **Claim Billing/Claim Rebill** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 45Ø-EF | Compound Dosage Form Description Code |  | M |  |
| 451-EG | Compound Dispensing Unit Form Indicator |  | M |  |
| 447-EC | Compound Ingredient Component Count | Maximum 25 ingredients | M |  |
| 488-RE | Compound Product ID Qualifier | 03 - NDC | M |  |
| 489-TE | Compound Product ID | 11 digit NDC | M |  |
| 448-ED | Compound Ingredient Quantity |  | M |  |
| 449-EE | COMPOUND INGREDIENT DRUG COST |  |  | *Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. |
| 49Ø-UE | COMPOUND INGREDIENT BASIS OF COST DETERMINATION |  |  | *Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. |

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| **\*\* End of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template\*\*** |

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| **\*\* Start of Request Claim Reversal (B2) Payer Sheet Template\*\*** |

***Claim Reversal (B2) NCPDP Version D.0***

**GENERAL INFORMATION**

|  |  |  |
| --- | --- | --- |
| Payer Name: Change HealthCare | Date: 04/04/2018 | |
| Plan Name/Group Name: Change Healthcare Commercial | BIN: 004682 | PCN: CN or Varies by Plan refer to Card |
| Plan Name/Group Name: Change Healthcare Commercial | BIN: 600426 | PCN: 54 or Varies by Plan refer to Card |
| Plan Name/Group Name: RX.Com | BIN: 014947 | PCN: PBC or RXC |
| Plan Name:/Group Name: Rx.Com | BIN: 015251 | PCN: PRX2000 |
| Plan Name/Group Name: MedAdvance | BIN: 022162 | PCN: NVH |
| Plan Name/Group Name: Clutch Health PBS | BIN: 022220 | PCN: CLP |
| Plan Name/Group Name: CareGuard | BIN: 022584 | PCN: AF |

**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. | No |

|  |  |
| --- | --- |
| **Question** | **Answer** |
| What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?) | Varies by plan |

**Claim Reversal Transaction**

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

|  |  |  |
| --- | --- | --- |
| **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 (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 |  |  |

|  | **Transaction Header Segment** |  |  | **Claim Reversal** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 1Ø1-A1 | BIN Number | See above | M |  |
| 1Ø2-A2 | Version/Release Number | DØ | M |  |
| 1Ø3-A3 | Transaction Code | B2 | M |  |
| 1Ø4-A4 | Processor Control Number | Varies by Plan | M |  |
| 1Ø9-A9 | Transaction Count | 1-4 | M |  |
| 2Ø2-B2 | Service Provider ID Qualifier | 01 = NPI | M |  |
| 2Ø1-B1 | Service Provider ID |  | M |  |
| 4Ø1-D1 | Date of Service |  | M |  |
| 11Ø-AK | Software Vendor/Certification ID | All Spaces | M |  |

|  |  |  |
| --- | --- | --- |
| **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 | *Imp Guide:* 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 | 03=NDC | M |  |
| 4Ø7-D7 | Product/Service ID | 11-digit NDC | M |  |
| 4Ø3-D3 | FILL NUMBER | New = 00 | M | *Imp Guide:* Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (4Ø2-D2) occur on the same day. |
| 3Ø8-C8 | OTHER COVERAGE CODE |  | M | *Imp Guide:* Required if needed by receiver to match the claim that is being reversed.  *Payer Requirement:* Must match original claim being reversed. |
| 147-U7 | pharmacy service type |  |  | *Imp Guide:* Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer. |
| 337-4C | Coordination of Benefits/Other Payments Count | Maximum count of 9. | M |  |
| 338-5C | Other Payer Coverage Type |  | M |  |
| 3Ø2-C2 | CARDHOLDER ID |  |  |  |
| 3Ø1-C1 | GROUP ID | **Multiple, refer to patient ID card for Group ID.** | R | *Imp Guide: Required if necessary, for state/federal/regulatory agency programs.*  *Required if needed for pharmacy claim processing and payment.* |
|  |  |  |  |  |
| **\*\* End of Request Claim Reversal (B2) Payer Sheet Template\*\*** | | | | | |

**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) Response**

|  |
| --- |
| **\*\* Start of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template\*\*** |

**GENERAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Payer Name: Change HealthCare | Date: 04/04/2018 | | |
| Payer Name: Change HealthCare | Date: 04/04/2018 | |
| Plan Name/Group Name: Change Healthcare Commercial | BIN: 004682 | PCN: CN or Varies by Plan refer to Card |
| Plan Name/Group Name: Change Healthcare Commercial | BIN: 600426 | PCN: 54 or Varies by Plan refer to Card |
| Plan Name/Group Name: RX.Com | BIN: 014947 | PCN: PBC or RXC |
| Plan Name:/Group Name: Rx.Com | BIN: 015251 | PCN: PRX2000 |
| Plan Name/Group Name: MedAdvance | BIN: 022162 | PCN: NVH |
| Plan Name/Group Name: Clutch Health PBS | BIN: 022220 | PCN: CLP |
| Plan Name/Group Name: CareGuard | BIN: 022584 | PCN: AF |

**Claim Billing/Claim Rebill PAID (or Duplicate of PAID) Response**

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

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

|  | **Response Transaction Header Segment** |  |  | **Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 1Ø2-A2 | Version/Release Number | DØ | M |  |
| 1Ø3-A3 | Transaction Code | B1, B3 | M |  |
| 1Ø9-A9 | Transaction Count | Same value as in request | M |  |
| 5Ø1-F1 | Header Response Status | A = Accepted | M |  |
| 2Ø2-B2 | Service Provider ID Qualifier | Same value as in request | M |  |
| 2Ø1-B1 | Service Provider ID | Same value as in request | M |  |
| 4Ø1-D1 | Date of Service | Same value as in request | M |  |

|  |  |  |
| --- | --- | --- |
| **Response Message Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  **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) = “2Ø”** |  |  | **Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 5Ø4-F4 | Message |  | RW | *Imp Guide:* Required if text is needed for clarification or detail.  *Payer Requirement: Same as implementation Guide* |

|  |  |  |
| --- | --- | --- |
| **Response Insurance Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  **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 Rebill – Accepted/Paid (or Duplicate of Paid)** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 545-2F | NETWORK REIMBURSEMENT ID |  |  | *Imp Guide:* Required if needed to identify the network for the covered member.  Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available.  Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist.  *Payer Requirement: Same as implementation Guide* |

|  |  |  |
| --- | --- | --- |
| **Response Status Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  **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 Rebill – Accepted/Paid (or Duplicate of Paid)** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 112-AN | Transaction Response Status | P=Paid  D=Duplicate of Paid | M |  |
| 5Ø3-F3 | AUTHORIZATION NUMBER |  | R | *Imp Guide:* Required if needed to identify the transaction.  *Payer Requirement: Same as implementation Guide* |
| 13Ø-UF | ADDITIONAL MESSAGE INFORMATION COUNT | Maximum count of 25. | RW | *Imp Guide:* Required if Additional Message Information (526-FQ) is used.  *Payer Requirement: Same as implementation Guide* |
| 132-UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER |  | RW | *Imp Guide:* Required if Additional Message Information (526-FQ) is used.  *Payer Requirement: Same as implementation Guide* |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION |  | RW | *Imp Guide:* Required when additional text is needed for clarification or detail.  *Payer Requirement: Same as implementation Guide* |
| 131-UG | ADDITIONAL MESSAGE INFORMATION CONTINUITY |  | RW | *Imp Guide:* 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.  *Payer Requirement: Same as implementation Guide* |
| 549-7F | HELP DESK PHONE NUMBER QUALIFIER |  | RW | *Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used.  *Payer Requirement: Same as implementation Guide* |
| 55Ø-8F | HELP DESK PHONE NUMBER |  | RW | *Imp Guide:* Required if needed to provide a support telephone number to the receiver.  *Payer Requirement: Same as implementation Guide* |

|  |  |  |
| --- | --- | --- |
| **Response Claim Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  **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 Rebill – 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 | *Imp Guide:* For Transaction Code of “B1”, in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing). |
| 4Ø2-D2 | Prescription/Service Reference Number |  | M |  |

|  |  |  |
| --- | --- | --- |
| **Response Pricing Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  **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 Rebill – Accepted/Paid (or Duplicate of Paid)** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 5Ø5-F5 | PATIENT PAY AMOUNT |  | R |  |
| 5Ø6-F6 | INGREDIENT COST PAID |  | R |  |
| 5Ø7-F7 | DISPENSING FEE PAID |  | R | *Imp Guide:* Required if this value is used to arrive at the final reimbursement.  *Payer Requirement: Same as implementation Guide* |
| 557-AV | TAX EXEMPT INDICATOR |  | RW | *Imp Guide:* Required if the sender (health plan) and/or patient is tax exempt and exemption applies to this billing.  *Payer Requirement: Same as implementation Guide* |
| 558-AW | FLAT SALES TAX AMOUNT PAID |  | RW | *Imp Guide:* 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.  *Payer Requirement: Same as implementation Guide* |
| 559-AX | PERCENTAGE SALES TAX AMOUNT PAID |  | RW | *Imp Guide:* Required if this value is used to arrive at the final reimbursement.  Required if Percentage Sales Tax Amount Submitted (482-GE) is greater than zero (Ø).  Required if Percentage Sales Tax Rate Paid (56Ø-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used.  *Payer Requirement: Same as implementation Guide* |
| 56Ø-AY | PERCENTAGE SALES TAX RATE PAID |  | RW | *Imp Guide:* Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).  *Payer Requirement: Same as implementation Guide* |
| 561-AZ | PERCENTAGE SALES TAX BASIS PAID |  | RW | *Imp Guide:* Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).  *Payer Requirement: Same as implementation Guide* |
| 521-FL | INCENTIVE AMOUNT PAID |  | RW | *Imp Guide:* Required if this value is used to arrive at the final reimbursement.  Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø).  *Payer Requirement: Same as implementation Guide* |
| 563-J2 | OTHER AMOUNT PAID COUNT | Maximum count of 3. | RW | *Imp Guide:* Required if Other Amount Paid (565-J4) is used.  *Payer Requirement: Same as implementation Guide* |
| 564-J3 | OTHER AMOUNT PAID QUALIFIER |  | RW | *Imp Guide:* Required if Other Amount Paid (565-J4) is used.  *Payer Requirement: Same as implementation Guide* |
| 565-J4 | OTHER AMOUNT PAID |  | RW | *Imp Guide:* Required if this value is used to arrive at the final reimbursement.  Required if Other Amount Claimed Submitted (48Ø-H9) is greater than zero (Ø).  *Payer Requirement: Same as implementation Guide* |
| 566-J5 | OTHER PAYER AMOUNT RECOGNIZED |  | RW | *Imp Guide:* Required if this value is used to arrive at the final reimbursement.  Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.  *Payer Requirement: Same as implementation Guide* |
| 5Ø9-F9 | TOTAL AMOUNT PAID |  | R |  |
| 522-FM | BASIS OF REIMBURSEMENT DETERMINATION |  | R | *Imp Guide:* Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø).  Required if Basis of Cost Determination (432-DN) is submitted on billing.  *Payer Requirement: Same as implementation Guide* |
| 523-FN | AMOUNT ATTRIBUTED TO SALES TAX |  | RW | *Imp Guide:* Required if Patient Pay Amount (5Ø5-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.  *Payer Requirement: Same as implementation Guide* |
| 517-FH | AMOUNT APPLIED TO PERIODIC DEDUCTIBLE |  | RW | *Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes deductible  *Payer Requirement:* (any unique payer requirement(s)) |
| 518-FI | AMOUNT OF COPAY |  | R | *Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes copay as patient financial responsibility.  *Payer Requirement: Same as implementation Guide* |
| 571-NZ | Amount Attributed to Processor Fee |  | RW | *Imp Guide:* Required if the customer is responsible for 1ØØ% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay.  *Payer Requirement: Same as implementation Guide* |
| 575-EQ | Patient sales tax amount |  | RW | *Imp Guide:* Used when necessary to identify the Patient’s portion of the Sales Tax. Provided for informational purposes only.  *Payer Requirement: Same as implementation Guide* |
| 574-2Y | Plan sales tax amount |  | RW | *Imp Guide:* Used when necessary to identify the Plan’s portion of the Sales Tax. Provided for informational purposes only.  *Payer Requirement: Same as implementation Guide* |
| 572-4U | Amount of Coinsurance |  | RW | *Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes coinsurance as patient financial responsibility.  *Payer Requirement: Same as implementation Guide* |
| 133-UJ | Amount Attributed to provider Network selection |  | RW | *Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another  *Payer Requirement: Same as implementation Guide* |
| 134-UK | amount attributed to product selection/brand drug |  | RW | *Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient’s selection of a Brand drug.  *Payer Requirement: Same as implementation Guide* |
| 135-UM | amount attributed to product selection/non-preferred formulary selection |  | RW | *Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient’s selection of a non-preferred formulary product.  *Payer Requirement: Same as implementation Guide* |
| 136-UN | amount attributed to product selection/Brand non-preferred formulary selection |  | RW | *Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient’s selection of a Brand non-preferred formulary product.  *Payer Requirement: Same as implementation Guide* |
| 148-U8 | INGREDIENT COST CONTRACTED/REIMBURSABLE AMOUNT |  | RW | *Imp Guide:* Required when Basis of Reimbursement Determination (522-FM) is “14” (Patient Responsibility Amount) or “15” (Patient Pay Amount) unless prohibited by state/federal/regulatory agency.  *Payer Requirement: Same as implementation Guide* |
| 149-U9 | DISPENSING FEE CONTRACTED/REIMBURSABLE AMOUNT |  | RW | *Imp Guide:* Required when Basis of Reimbursement Determination (522-FM) is “14” (Patient Responsibility Amount) or “15” (Patient Pay Amount) unless prohibited by state/federal/regulatory agency.  *Payer Requirement: Same as implementation Guide* |

|  |  |  |
| --- | --- | --- |
| **Response DUR/PPS Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  **Accepted/Paid (or Duplicate of Paid)**  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 Rebill – 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 | *Imp Guide:* Required if Reason For Service Code (439-E4) is used.  *Payer Requirement: Same as implementation Guide* |
| 439-E4 | REASON FOR SERVICE CODE |  | RW | *Imp Guide:* Required if utilization conflict is detected.  *Payer Requirement: Same as implementation Guide* |
| 528-FS | CLINICAL SIGNIFICANCE CODE |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict.  *Payer Requirement: Same as implementation Guide* |
| 529-FT | OTHER PHARMACY INDICATOR |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict.  *Payer Requirement: Same as implementation Guide* |
| 53Ø-FU | PREVIOUS DATE OF FILL |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict.  Required if Quantity of Previous Fill (531-FV) is used.  *Payer Requirement: Same as implementation Guide* |
| 531-FV | QUANTITY OF PREVIOUS FILL |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict.  Required if Previous Date Of Fill (53Ø-FU) is used.  *Payer Requirement: Same as implementation Guide* |
| 532-FW | DATABASE INDICATOR |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict.  *Payer Requirement: Same as implementation Guide* |
| 533-FX | OTHER PRESCRIBER INDICATOR |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict.  *Payer Requirement: Same as implementation Guide* |
| 544-FY | DUR FREE TEXT MESSAGE |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict.  *Payer Requirement: Same as implementation Guide* |
| 57Ø-NS | DUR ADDITIONAL TEXT |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict.  *Payer Requirement: Same as implementation Guide* |

|  |  |  |
| --- | --- | --- |
| **Response Coordination of Benefits/Other Payers Segment Questions** | **Check** | **Claim Billing/Claim Rebill**  **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 Rebill – 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 | *Imp Guide:* Required if Other Payer ID (34Ø-7C) is used. |
| 34Ø-7C | OTHER PAYER ID |  | RW | *Imp Guide:* Required if other insurance information is available for coordination of benefits. |
| 992-MJ | OTHER PAYER GROUP ID |  | RW | *Imp Guide:* Required if other insurance information is available for coordination of benefits. |

**Claim Billing/Claim Rebill accepted/rejected Response**

|  |  |  |
| --- | --- | --- |
| **Response Transaction Header Segment Questions** | **Check** | **Claim Billing/Claim Rebill Accepted/Rejected**  If Situational, *Payer Situation* |
| This Segment is always sent | X |  |

|  | **Response Transaction Header Segment** |  |  | **Claim Billing/Claim Rebill Accepted/Rejected** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 1Ø2-A2 | Version/Release Number | DØ | M |  |
| 1Ø3-A3 | Transaction Code | B1, B3 | M |  |
| 1Ø9-A9 | Transaction Count | Same value as in request | M |  |
| 5Ø1-F1 | Header Response Status | A = Accepted | M |  |
| 2Ø2-B2 | Service Provider ID Qualifier | Same value as in request | M |  |
| 2Ø1-B1 | Service Provider ID | Same value as in request | M |  |
| 4Ø1-D1 | Date of Service | Same value as in request | M |  |

|  |  |  |
| --- | --- | --- |
| **Response Message Segment Questions** | **Check** | **Claim Billing/Claim Rebill Accepted/Rejected**  If Situational, *Payer Situation* |
| This Segment is always sent |  |  |
| This Segment is situational |  |  |

|  | **Response Message Segment**  **Segment Identification (111-AM) = “2Ø”** |  |  | **Claim Billing/Claim Rebill Accepted/Rejected** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 5Ø4-F4 | MESSAGE |  | RW | *Imp Guide:* Required if text is needed for clarification or detail. |

|  |  |  |
| --- | --- | --- |
| **Response Insurance Segment Questions** | **Check** | **Claim Billing/Claim Rebill 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 Rebill Accepted/Rejected** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 545-2F | NETWORK REIMBURSEMENT ID |  | RW | *Imp Guide:* Required if needed to identify the network for the covered member.  Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available.  Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist. |
|  |  |  |  |  |

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

|  | **Response Status Segment**  **Segment Identification (111-AM) = “21”** |  |  | **Claim Billing/Claim Rebill Accepted/Rejected** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 112-AN | TRANSACTION RESPONSE STATUS | R = Reject | M |  |
| 5Ø3-F3 | AUTHORIZATION NUMBER |  |  | *Imp Guide:* Required if needed to identify the transaction. |
| 51Ø-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. |
| 13Ø-UF | ADDITIONAL MESSAGE INFORMATION COUNT | Maximum count of 25. | RW | *Imp Guide:* Required if Additional Message Information (526-FQ) is used. |
| 132-UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER |  | RW | *Imp Guide:* Required if Additional Message Information (526-FQ) is used. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION |  | RW | *Imp Guide:* Required when additional text is needed for clarification or detail. |
| 131-UG | ADDITIONAL MESSAGE INFORMATION CONTINUITY |  | RW | *Imp Guide:* 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. |
| 549-7F | HELP DESK PHONE NUMBER QUALIFIER |  | RW | *Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used. |
| 55Ø-8F | HELP DESK PHONE NUMBER |  | RW | *Imp Guide:* Required if needed to provide a support telephone number to the receiver. |
| 987-MA | URL |  | RW | *Imp Guide:* Provided for informational purposes only to relay health care communications via the Internet. |

|  |  |  |
| --- | --- | --- |
| **Response Claim Segment Questions** | **Check** | **Claim Billing/Claim Rebill Accepted/Rejected**  If Situational, *Payer Situation* |
| This Segment is always sent | X |  |

|  | **Response Claim Segment**  **Segment Identification (111-AM) = “22”** |  |  | **Claim Billing/Claim Rebill Accepted/Rejected** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 455-EM | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER | 1 = RxBilling | M | *Imp Guide:* For Transaction Code of “B1”, in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing). |
| 4Ø2-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER |  | M |  |
| 556-AU | PREFERRED PRODUCT DESCRIPTION |  |  | *Imp Guide:* Required if a product preference exists that either cannot be communicated by the Preferred Product ID (553-AR) or to clarify the Preferred Product ID (553-AR). |

|  |  |  |
| --- | --- | --- |
| **Response DUR/PPS Segment Questions** | **Check** | **Claim Billing/Claim Rebill 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 Rebill Accepted/Rejected** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 567-J6 | DUR/PPS RESPONSE CODE COUNTER | Maximum 9 occurrences supported. | RW | *Imp Guide:* Required if Reason For Service Code (439-E4) is used. |
| 439-E4 | REASON FOR SERVICE CODE |  | RW | *Imp Guide:* Required if utilization conflict is detected. |
| 528-FS | CLINICAL SIGNIFICANCE CODE |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict. |
| 529-FT | OTHER PHARMACY INDICATOR |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict. |
| 53Ø-FU | PREVIOUS DATE OF FILL |  | RW | *Imp Guide:* 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 | *Imp Guide:* Required if needed to supply additional information for the utilization conflict.  Required if Previous Date Of Fill (53Ø-FU) is used. |
| 532-FW | DATABASE INDICATOR |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict. |
| 533-FX | OTHER PRESCRIBER INDICATOR |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict. |
| 544-FY | DUR FREE TEXT MESSAGE |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict. |
| 57Ø-NS | DUR ADDITIONAL TEXT |  | RW | *Imp Guide:* Required if needed to supply additional information for the utilization conflict. |

**Claim Billing/Claim Rebill Rejected/Rejected Response**

**Claim Billing/Claim Rebill Rejected/Rejected Response**

|  |  |  |
| --- | --- | --- |
| **Response Transaction Header Segment Questions** | **Check** | **Claim Billing/Claim Rebill Rejected/Rejected**  If Situational, *Payer Situation* |
| 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* |
| 1Ø2-A2 | Version/Release Number | DØ | M |  |
| 1Ø3-A3 | Transaction Code | B1, B3 | M |  |
| 1Ø9-A9 | Transaction Count | Same value as in request | M |  |
| 5Ø1-F1 | Header Response Status | R = Rejected | M |  |
| 2Ø2-B2 | Service Provider ID Qualifier | Same value as in request | M |  |
| 2Ø1-B1 | Service Provider ID | Same value as in request | M |  |
| 4Ø1-D1 | Date of Service | Same value as in request | M |  |

|  |  |  |
| --- | --- | --- |
| **Response Message Segment Questions** | **Check** | **Claim Billing/Claim Rebill Rejected/Rejected**  If Situational, *Payer Situation* |
| This Segment is always sent |  |  |
| This Segment is situational |  |  |

|  | **Response Message Segment**  **Segment Identification (111-AM) = “2Ø”** |  |  | **Claim Billing/Claim Rebill Rejected/Rejected** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 5Ø4-F4 | MESSAGE |  | RW | *Imp Guide:* Required if text is needed for clarification or detail. |

|  |  |  |
| --- | --- | --- |
| **Response Status Segment Questions** | **Check** | **Claim Billing/Claim Rebill Rejected/Rejected**  If Situational, *Payer Situation* |
| 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 |  |
| 5Ø3-F3 | AUTHORIZATION NUMBER |  | R | *Imp Guide:* Required if needed to identify the transaction. |
| 51Ø-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. |
| 13Ø-UF | ADDITIONAL MESSAGE INFORMATION COUNT | Maximum count of 25. | RW | *Imp Guide:* Required if Additional Message Information (526-FQ) is used. |
| 132-UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER |  | RW | *Imp Guide:* Required if Additional Message Information (526-FQ) is used. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION |  | RW | *Imp Guide:* Required when additional text is needed for clarification or detail. |
| 131-UG | ADDITIONAL MESSAGE INFORMATION CONTINUITY |  | RW | *Imp Guide:* 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. |
| 549-7F | HELP DESK PHONE NUMBER QUALIFIER |  | RW | *Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used. |
| 55Ø-8F | HELP DESK PHONE NUMBER |  | RW | *Imp Guide:* Required if needed to provide a support telephone number to the receiver. |

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| **\*\* End of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template\*\*** |