

NCPDP PAYER SHEET TEMPLATE

IMPLEMENTATION GUIDE FOR VERSION D.0 VERSION 18

Used as guidance in filling out and creating a NCPDP Telecommunication Standard Implementation-based Version D.0 Payer Sheet, in accordance with the NCPDP Telecommunication Standard Implementation Guide vD.0 (August 2007) and CMS-0055 Final Rule published January 24, 2020.

September 2024

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NCPDP Payer Sheet Template

Version 18

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1. GENERAL INFORMATION FOR A PAYER ABOUT THE TEMPLATES

This document is to be used as a reference in filling out and creating a Payer Sheet based on NCPDP *Telecommunication Standard Implementation Guide Version D.0*. The Payer Sheet must contain request and response information.

Payers must read the [instructional sections](#) before filling out the templates. Payers may take the [request template section](#) and [response template section](#), fill out the template per their usage and send to their trading partners. Payer Sheets may be used in addition to provider manuals or included in provider manuals. Payers must indicate applicable fields to be used in transaction processing, in accordance with the rules established in the NCPDP documents and the Quantity Prescribed final rule as indicated under CMS-0055 F. Refer to the NCPDP Telecommunication Version D documents, *Telecommunication Standard Implementation Guide Version D.0*, *Data Dictionary*, *External Code List* and *Telecommunication Version D Questions, Answers and Editorial Updates*. For specific information related to Quantity Prescribed refer to [Quantity Prescribed \(460-ET\) Guidance](https://www.ncdp.org/Resources/Quantity-Prescribed-(460-ET)-Guidance) ([https://www.ncdp.org/Resources/Quantity-Prescribed-\(460-ET\)-Guidance](https://www.ncdp.org/Resources/Quantity-Prescribed-(460-ET)-Guidance)).

In this document, the following templates have been created:

- [Claim Billing/Claim Rebill](#)
 - Request
 - Responses (Paid and Rejected)
- [Claim Reversal](#)
 - Request
 - Responses (Approved and Rejected)

Payers should fill out a template for each request and response transaction supported. If other transactions are supported (Service Billing request and responses, Service Reversal request and responses, Prior Authorization Inquiry request and responses, etc.), payer templates should be created following the guidelines in this document. Payers are reminded to fill out a template for each response type supported **including** the Rejected transmission and Rejected transaction response.

If the payer does not support the Claim Rebill (B3) transaction, the Claim Rebill verbiage should be removed from the payer's template.

The [Examples](#) sections show how segments and fields on payer sheets might be filled out.

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1.2 EXTERNAL CODE LIST

In the General Information section of the Payer Template, the **NCPDP External Code List Publication Date** is designated by the payer. If the payer supports an updated publication date of the NCPDP *External Code List*, the payer template must be republished with any applicable new information. Refer to the Telecommunication annual and emergency external code list process and dates outlined within the web-enabled ECL.

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2. GENERAL INSTRUCTIONS TO PAYERS

2.1 HOW TO USE THIS DOCUMENT

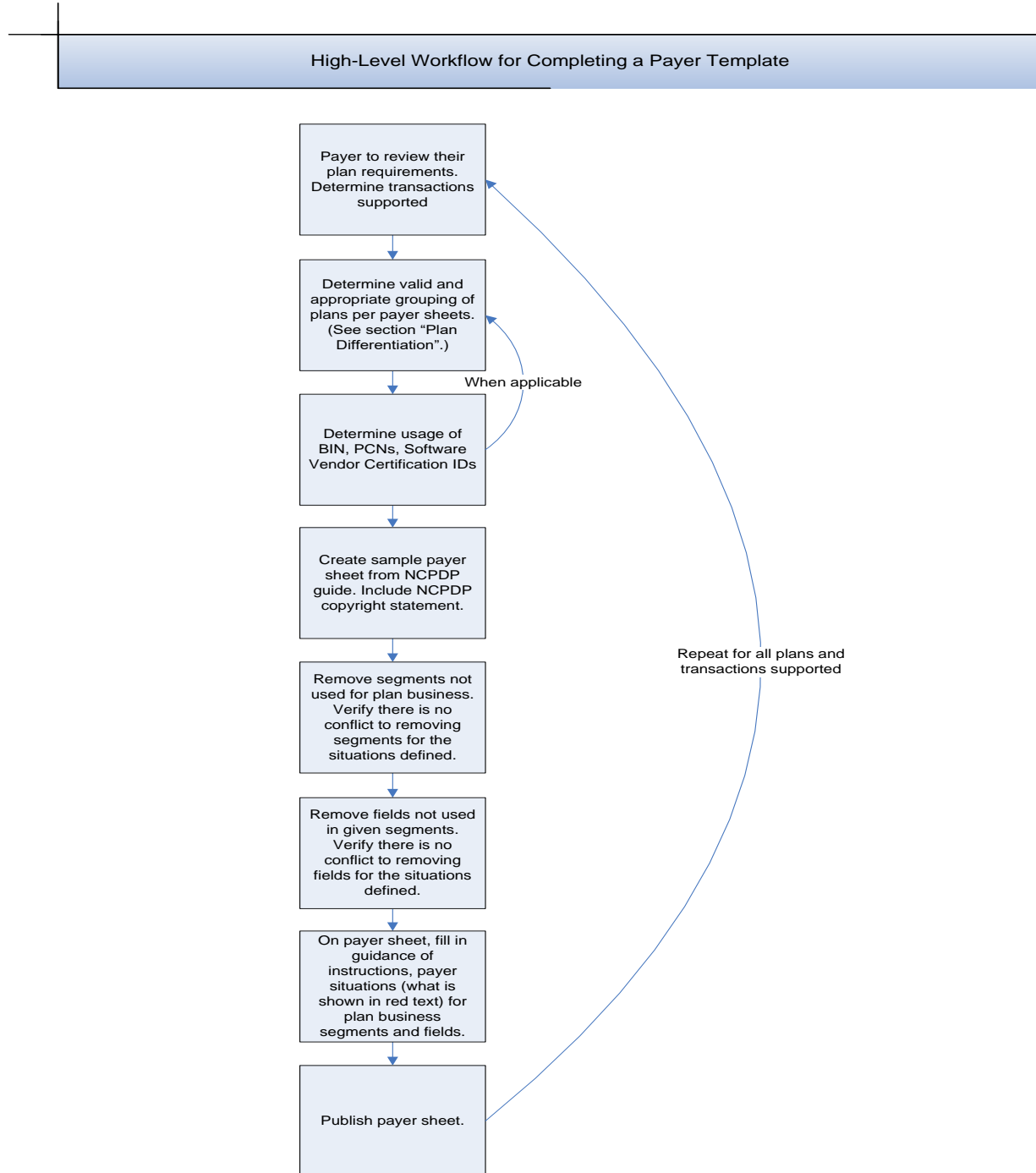


Figure 1. High-level workflow

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2.2 TRANSMISSIONS

Refer to the NCPDP *Telecommunication Standard Implementation Guide Version D.0* for the structure and syntax of the transaction(s) within the transmission.

In the template, the Segment Identification (112-AM) fields are not shown. Segment, Group and Field Separators are not shown as they are part of the syntax. These fields are not shown because they are part of the underlying structure of the transaction and are covered in the guide. This template is to show the business and plan requirements.

2.3 PLAN DIFFERENTIATION

If the payer does not have different plans, this section can be skipped.

If the payer supports multiple plans or has different BINs and/or PCNs that cause different segments to be used, different payer sheets must be created for each unique combination. Coordination of Benefits (COB) is one example where various claims processing rules may apply based on plan or BIN/PCN. NCPDP recommends there only be one COB method used for a single BIN/PCN combination.

Examples where multiple payer sheets should be used include:

- Plans that use different COB methodology
 - Plans that are Primary only (i.e., Coordination of Benefits/Other Payments Segment not used) should not be combined with plans that are supplemental (i.e., COB Segment used)
 - Plans that use different COB scenarios (OPAP, OPPRA or Government COB) must have different payer sheets as they should have different BIN/PCN combinations.
- Payers where one or more plans use the Workers' Compensation Segment while others do not
- Payers where one or more plans use the Coupon Segment while others do not

Because a payer sheet may be created that represents the "superset" of requirements for multiple plans, the pharmacy will submit based on this "superset". An individual plan(s) benefit under this "superset" may not require all of the fields in the "superset." In this instance, the plan will ignore the fields that do not apply to the particular transaction being submitted. For example:

- One plan or more uses Patient Gender Code while others covered in the same template do not.

Examples include

Scenario Examples	BIN	PCN	Different Payer Templates Required?	Comment
The payer supports one BIN with multiple PCNs where some plans are Primary only and others are supplemental.	223346	PCN = XYZ (Primary only) PCN = BBC (Supplemental) PCN = GAR (Supplemental)	Yes	Since one of the plans is Primary only, it needs a separate payer sheet.
The payer supports one BIN with multiple PCNs. Each PCN supports the same method of coordination of benefit processing.	223346	PCN = XYZ PCN = BBC PCN = GAR	No	Since all plans under this BIN have the same segments, the same Payer Template can be used. (See section Specific Topic Discussion)
The payer supports Workers' Compensation claims and non-Workers' Compensation claims under the same BIN.	610041	PCN = WRK for Workers' Compensation claims PCN = ABC for non-Workers' Compensation claims.	Yes	Two Payer Templates must be used because different segments are used. (Workers' Compensation claims will use the Workers' Compensation Segment; non-Workers' Compensation claims do not use the Workers' Compensation Segment)
The payer supports coupons claims and non-coupon claims under the same BIN.	044356	Has no impact	Yes	Two Payer Templates must be used because different segments are used. (Coupon transactions will use the Coupon Segment; non-Coupon transactions do not use the Coupon Segment)
The payer supports claim and service billings under the same BIN.	112234	Has no impact	Yes	Two Payer Templates must be used to avoid confusion in segments used for claim billing versus service billing.
The payer supports a plan	662211	Has no impact	No	One Payer Template should be used

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Scenario Examples	BIN	PCN	Different Payer Templates Required?	Comment
that may be primary or supplemental.				since all segments used are the same, with the exception of the Coordination of Benefits/Other Payments Segment which will designate the usage of the supplemental rules.
The processor supports plans that require their own BINs.	445511 887766	Has no impact	No	Since all plans for this processor have the same segments the same Payer Template can be used. (See section Specific Topic Discussion)
The processor supports numerous plans and BINS that use the three different COB Methods	112234 223346 445511 887766	May impact	Yes	Three Payer Templates must be used, one for each of the different COB methods (Scenario 1 – Other Payer Amount Paid (OPAP), Scenario 2 – Other Payer Patient Responsibility Amount (OPRA) and Scenario 3 – Government Programs)

2.4 SEGMENTS

Each segment is listed as mandatory, situational or optional for a given transaction in the NCPDP *Telecommunication Standard Implementation Guide*. If the segment is mandatory for a given transaction, that segment must be sent. If the segment is situational, the situations outlined in the guide must be followed for use. If the segment is optional, please refer to the NCPDP *Telecommunication Standard Implementation Guide Version D.0* for more information on optional usage.

2.4.1 MANDATORY SEGMENTS

Segments which are designed mandatory in the NCPDP *Telecommunication Standard Implementation Guide* must be included on the Payer Sheet. In the mandatory segments, the Payer must fill in the values to be used in the mandatory or situational fields as defined in the NCPDP *Telecommunication Standard Implementation Guide*.

On the template, each mandatory **segment** contains an initial question about the use of the segment (This Segment is always sent), with an “X” in the Check column. The Check “X” is in black and must not be modified by the Payer. An example:

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

2.4.2 SITUATIONAL SEGMENTS

On the template, each **situational segment** contains two initial questions about the use of the segment (This Segment is always sent) and (This Segment is situational). The Check “X” in **red text** and the Payer must answer either of the initial questions with a check. If the Segment is situational, a situation for when the Segment is used must be described. An example:

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>(Situation required)</i>

Or

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent	X	<i>(No Situation is required)</i>
This Segment is situational		

The payer must:

1. If this situational segment is Not Used by the Payer, the segment and charts **must not be shown** (the initial question chart and the segment with fields chart should be deleted).
2. If this situational segment is used by the Payer,
 - a. Either the question “This Segment is always sent” or “This Segment is situation” must contain a Check “X” on the template for each situational segment. This tells the reader how the segment is supported in this transaction.
 - i. If “This Segment is always sent” is checked
 1. The segment is used in every transaction associated with this template.

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2. In the field charts, the Payer must list the fields supported and all situations applicable.
3. In the field charts, the Payer must exclude Not Used fields.
- ii. If “This Segment is always situational” is checked
 1. The segment is used in some of the business cases of this transaction.
 2. The Payer should provide guidance when this segment is used in the “If Situational, *Payer Situation*” column.
 3. In the field charts, the Payer must list the fields supported and all situations applicable.
 4. In the field charts, the Payer must exclude Not Used fields.

If column is not applicable, it will be shaded (for example, “If Situational, *Payer Situation*” cell above for the question “This Segment is always sent”).

2.4.3 OPTIONAL SEGMENTS

The NCPDP *Telecommunication Standard Implementation Guide Version D.0* allows segments defined as optional in the Controlled Substance Reporting transactions only. Use the methodology shown below for optional segments.

On the template, the **optional segment** contains two initial questions about the use of the segment (This Segment is always sent) and (This Segment is optional). The Check “X” in red text and the Payer must answer either of the initial questions with a check. If the Segment is optional, a situation for when the Segment is used must be described. An example:

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Defined Usage</i>
This Segment is always sent		
This Segment is optional	X	(Supporting information)
<i>Or</i>		
Prescriber Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Defined Usage</i>
This Segment is always sent	X	(No Supporting Information is required)
This Segment is optional		

2.5 FIELDS OR VALUES

2.5.1 SITUATIONS ON FIELDS

The Payer template has been pre-filled in the Payer Situation column with the field-level situations from the NCPDP *Telecommunication Standard Implementation Guide Version D.0*. These pre-filled situations begin with the tag “*Imp Guide:*” Note: *The Quantity Prescribed field (460-ET) reflects the required use of this field for Schedule II drugs as defined under CMS-0055 F.*

If the payer wishes to further define the situation and explain its usage, situations can be added to the tag “*Payer Requirement:*” If the NCPDP *Telecommunication Standard Implementation Guide Version D.0* situation satisfies the payer’s instructions, the statement can be entered “*Payer Requirement: Same as Imp Guide.*”

For example:

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
414-DE	DATE PRESCRIPTION WRITTEN		R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Submission Clarification Code (420-DK) is used. <i>Payer Requirement:</i> Same as Imp Guide.

It is very important that the NCPDP *Telecommunication Standard Implementation Guide Version D.0* and above be consulted for full information on field usage.

The following is an example of a pre-filled situation for a field. The tag “*Imp Guide:*” contains the field-level situation from the Imp Guide (*Imp Guide:* Required when the patient has a first name.). The tag “*Payer Requirement:*” contains further guidance of the situation(s) from the payer (*Payer Requirement:* Required as all patients are enrolled with a first name. If newborn, use “BABY BOY” or “BABY GIRL.” If person has only one name, put one name in this field.).

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME		RW	<p><i>Imp Guide:</i> Required when the patient has a first name.</p> <p><i>Payer Requirement:</i> Required as all patients are enrolled with a first name. If newborn, use "BABY BOY" or "BABY GIRL." If person has only one name, put one name in this field.</p>

2.5.2 COUNTS AND COUNTERS

Each count and counter field has a maximum number of occurrences allowed in the NCPDP *Telecommunication Standard Implementation Guide*. If the payer supports less than the maximum number of occurrences, this must be explained for the appropriate field in the "Payer Situation" column of the template.

For example:

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
458-SE	PROCEDURE MODIFIER CODE COUNT	Maximum count of 10.		<p><i>Imp Guide:</i> Required if Procedure Modifier Code (459-ER) is used.</p> <p><i>Payer Requirement:</i></p>

2.5.3 ZERO (0) AND AN "O"

When denoting a field or a value, the slashed zero (ø) should be used to clearly differentiate between a zero (0) and an "O". This is not a requirement but is highly recommended for clarity.

2.6 SPECIFIC TOPIC DISCUSSION

2.6.1 PARTIAL FILL TRANSACTION PROCESSING

If the NCPDP Partial Fill logic that is specific to inventory shortage is supported by the payer, "Payer supports partial fills" should be checked. If not supported, "Payer does not support partial fills" should be checked. (See *Claim Segment* in section [Request Claim Billing/Claim Rebill Payer Sheet Template](#)) Refer to the NCPDP *Telecommunication Implementation Guide Version D.0* section "Specific Segment Discussion", "Request Segments", "Claim Segment", "Partial Fill".

2.6.2 QUANTITY PRESCRIBED (460-ET)

On January 24, 2020, Health and Human Services published the Final Rule: Administrative Simplification: Modification of the Requirements for the Use of Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Council for Prescription Drug Programs (NCPDP) D.0 Standard: CMS-0055-F. As indicated below this rule requires a modification to how the Quantity Prescribed (460-ET) field is used in the 2007 publication of the NCPDP *Telecommunication Version D.0 Standard*.

"§ 162.1102 Standards for health care claims or equivalent encounter information transaction.

** * * * **

(d) For the period on and after September 21, 2020, the Quantity Prescribed (460-ET) field, as set forth in the Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007 and equivalent Batch Standard Implementation Guide, Version 1, Release 2 (Version 1.2), National Council for Prescription Drug Programs, must be treated as required where the transmission meets both of the following:

- (1) Is for a Schedule II drug, as defined in 21 CFR 1308.12.*
- (2) Uses the standard identified in paragraph (b)(2)(i) of this section."*

Payer Sheets must be updated to reflect implementation of the Final Rule.

2.6.3 COORDINATION OF BENEFITS (COB) PROCESSING

If the Coordination of Benefits Segment is used, indicate if payer will be requiring providers to report:

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1. Scenario 1 - Other Payer Amount Paid Repetitions Only or
2. Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only or
3. Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount and Benefit Stage Repetitions Present (Government Programs).

(Note: For additional information on the scenarios, see *Coordination Of Benefits/Other Payments Segment*, in section [Request Claim Billing/Claim Rebill Payer Sheet Template](#))

Only one scenario method may be supported per template. The template shows the Coordination of Benefits/Other Payments Segment that must be used for each scenario method. The payer must choose the appropriate scenario method with the segment chart and delete the other scenario methods with their segment charts.

For Coordination of Benefits (COB) the following considerations and information should be provided in the payer sheets:

1. When is the COB segment sent?
 - a. "This Segment is always sent" must be checked if the payer is **always** a secondary or supplemental plan.
 - b. "This Segment is situational" must be checked if the payer is sometimes a secondary or supplemental plan.
 - c. When a payer does not support COB processing, this would be indicated in the COB segment section by checking "COB Segment not supported."
2. If there is a different Help Desk phone number related to COB inquiries, it should be provided.

If additional information is needed, see section "Specific Segment Discussion", "Request Segments", "Coordination of Benefits/Other Payments Segment" and section "Standard Conventions", "Repetition and Multiple Occurrences", "Repeating Data Elements", "Request Segments", "Coordination of Benefits/Other Payments Segment" of the NCPDP Telecommunication Standard Implementation Guide Version D.0 for information important to processing coordination of benefits.

2.6.4 COMPOUNDS

In the NCPDP Telecommunication Standard Implementation Guide Version D.0 there is only one way for the pharmacy to submit and the processor to adjudicate compound claims.

- Use the Compound Segment for multi-ingredient prescriptions

The other options allowed in previous implementation guides which **are no longer** supported by the Standard:

- Determine and submit the most expensive legend drug's NDC with the quantity of the dispensed product
- The use of billing codes or dummy NDC values

2.6.5 VACCINE ADMINISTRATION

For vaccine administration, Medicare Part D should be handled the same way in version 5.1 and D.0. For all other payers - If the vaccine administration fee is part of the drug benefit cost, the Medicare Part D-based Claim Billing method can be used. Information is found in the **Telecommunication Version 5 Questions, Answers and Editorial Updates** document (http://www.ncdp.org/public_documents.aspx?v5ed).

If the vaccine administration fee is not part of the drug benefit cost, the Claim Billing is used for the drug benefit cost, and the Service Billing is to be used to bill the administration fee. The payer sheet should designate which way supported – if the vaccine administration is part of the drug benefit cost, the appropriate fields should be designated on the Claim Billing. If vaccine administration is not part of the drug benefit cost, the Service Billing payer sheet is to be provided.

2.7 FIELD LEGEND

This legend is used by the payer to determine how to complete the Payer Template for the field designations.

Telecommunication Implementation Guide Designation	Implementation Guide Value	Explanation	Payer Sheet Value	Payer Situation Defined
MANDATORY	M	The Field is mandatory for the Segment in the Transaction. Mandatory elements have structural requirements.	M	
SITUATIONAL		The Field has been further designated as "R" or "Q" as shown below.		
Required	R	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	R	
Qualified Requirement	Q	The situations designated have qualifications for usage ("Required if x",	RW (Required When).	Yes for RW

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Telecommunication Implementation Guide Designation	Implementation Guide Value	Explanation	Payer Sheet Value	Payer Situation Defined
		"Not required if y").	If NA (Not Applicable by the Payer), do not list field.	
INFORMATIONAL ONLY	I	The Field is for informational purposes only in the designated Transaction. For response fields, if the payer supports the business usage, the informational field should be returned.	RW (Required When). If NA (Not Applicable by the Payer), do not list field.	Yes for RW
OPTIONAL	O	The Field has been designated as optional usage (situations were intentionally not defined). Limited usage. See requirements in NCPDP <i>Telecommunication Standard Implementation Guide</i> .	RW (Required When). If NA (Not Applicable by the Payer), do not list field.	Yes for RW
NOT USED	N	The Field is not used for the Segment in the designated Transaction. Not used are shaded for clarity.	If NA (Not Applicable by the Payer), do not list field.	

Further explanation of this legend follows.

2.8 MANDATORY FIELDS

Field Legend above: If a field is designated as “M” (Mandatory) in the NCPDP *Telecommunication Implementation Guide Version D.0*, the only “Payer Sheet Value” is “M” (Mandatory). The payer may not define a situation (column “Payer Situation Defined” = No).

On the Payer Template: The “Payer Usage” column is “M” and the “Payer Situation” column is not filled out. The “Value” column of the template may contain instructional material. The template indicates the mandatory fields for each segment, as defined by the NCPDP *Telecommunication Standard Implementation Guide Version D.0*. These are the **only** fields that have the “Mandatory” designation on the template.

2.9 SITUATIONAL FIELDS - REQUIRED

Field Legend above: If a field is designated as “R” (Required) in the NCPDP *Telecommunication Implementation Guide Version D.0* **for this transaction**, the only “Payer Sheet Value” is “R” (Required). The payer may not define a situation (column “Payer Situation Defined” = No) as the situation is “Required.”

On the Payer Template: The “Payer Usage” column is “R” and the “Payer Situation” column is not filled out. The “Value” column of the template may contain instructional material.

2.10 SITUATIONAL FIELDS – QUALIFIED REQUIREMENT

Field Legend above: If a field is designated as “Q” (Qualified Requirement) in the NCPDP *Telecommunication Implementation Guide Version D.0* **for this transaction**, the field may be used according to the situations defined in the implementation guide or not used.

On the Payer Template: The only “Payer Sheet Values” is “RW” (Required When). If “RW”, then “Payer Situation Defined” = Yes and the “Payer Situation” column **must** contain guidance for the implementer based on the situation(s) allowed by the NCPDP *Telecommunication Implementation Guide Version D.0* **for this transaction**. The “Value” column of the template will contain instructional material.

If the field is not used, payers must not include the field in the segment (the row in the table should be deleted). Payers are **not** allowed to list the field with an “NA” (Not Applicable by the Payer) designation.

2.11 INFORMATIONAL ONLY FIELDS

Field Legend above: Fields that are defined with situations of “I” (Informational Only) **for this transaction** in the NCPDP *Telecommunication Standard Implementation Guide Version D.0* provide additional data related to the transaction. If the field is designated as “I” (Informational Only) **for this transaction**, the field may be used according to the situations defined in the implementation guide or not used.

On the Payer Template: The only “Payer Sheet Values” is “RW” (Required When). If “RW”, then “Payer Situation Defined” = Yes and the column “Payer Situation” **must** contain guidance for the implementer based on the situation(s) allowed by the NCPDP *Telecommunication Implementation Guide Version D.0* **for this transaction**.

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If the field is not used, payers must not include the field in the segment (the row in the table should be deleted). Payers are **not** allowed to list the field with an “NA” (Not Applicable by the Payer) designation.

For response fields, if the payer supports the business usage, the informational field should be returned.

2.12 OPTIONAL FIELDS

Field Legend above: Fields that are defined with situations of “O” (Optional) for this transaction in the NCPDP *Telecommunication Standard Implementation Guide Version D.0* are fields in limited environments. Please refer to the guide for more information on optional field usage. The field may be not used.

On the Payer Template: The only “Payer Sheet Values” is “RW” (Required When). When the “Payer Usage” column is “RW” (Required When), the column “Payer Situation” must contain guidance for the implementer. Optional fields are limited and usage between trading partners must be well defined. See the requirements in the NCPDP *Telecommunication Standard Implementation Guide*.

If the field is not used, Payers must not include the field in the segment (the row in the table should be deleted). Payers are **not** allowed to list the field with an “NA” (Not Applicable by the Payer) designation.

2.13 NOT USED FIELDS

Field Legend above: Fields that are defined with situations of “Not Used” in the NCPDP *Telecommunication Standard Implementation Guide Version D.0* for this transaction are not allowed to be used in the transaction.

On the Payer Template: There is no “Payer Sheet Value” designated as the field must not be included in the chart. If the field is not used, payers must not include the field in the segment (the row in the table should be deleted). Payers are **not** allowed to list the field with an “NA” (Not Applicable by the Payer) designation.

NOTE: CMS-0055-F creates an exception to the above ‘Not Used’ field designation for the Quantity Prescribed field (460-ET). Payer sheets should reflect the use of this field as ‘Required for Schedule II drugs,’ as indicated within the final rule. For specific information related to Quantity Prescribed refer to [Quantity Prescribed \(460-ET\) Guidance \(https://www.ncdp.org/Resources/Quantity-Prescribed-\(460-ET\)-Guidance\)](https://www.ncdp.org/Resources/Quantity-Prescribed-(460-ET)-Guidance).

3. NCPDP VERSION D CLAIM BILLING/CLAIM REBILL INSTRUCTIONS

3.1 GENERAL INFORMATION

Areas of red text on the template are to be replaced by payer-designated information where applicable. Areas of black text on the template are not to be modified by the payer, unless it is to remove a row for a field that is not applicable.

Examples of payer sheet templates filled out can be found in section [“Examples of Payer Templates”](#).

If the payer does not support the Claim Rebill (B3) transaction, the Claim Rebill verbiage should be removed from the payer’s template.

3.2 REQUEST TEMPLATE INFORMATION

Sections [“Instructions to Payers”](#) and [“Field Legend”](#) must be followed.

The template information includes

- General Information
- Other Transactions Supported
- Field Legend for Columns
- Claim Billing/Claim Rebill Transaction (segments and fields)

3.3 RESPONSE TEMPLATE INFORMATION

The Claim Billing/Claim Rebill response template defines the Claim Billing response transaction for a Paid or Rejected response. Payers should fill out a separate template for each transaction supported, with each response supported, as appropriate (for example, for Claim Billing – Paid, Reject, Captured, etc. response; for Service Billing – Paid, Rejected, etc. response; for Reversal – Approved, Rejected, etc. response) as appropriate for their business.

Sections [“Instructions to Payers”](#) and [“Field Legend”](#) must be followed.

The template information includes

- General Information
- Field Legend for Columns
- Claim Billing Transaction Response (segments and fields)

3.4 CERTIFICATION AND/OR TEST DATA

If a payer wishes to include certification requirements and/or test data for claims processing, these sections can be included after the templates. Some payers provide certification requirements in a separate certification package which is separate from the templates.

4. NCPDP VERSION D CLAIM BILLING/CLAIM REBILL TEMPLATE

4.1 REQUEST CLAIM BILLING/CLAIM REBILL PAYER SHEET TEMPLATE

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

GENERAL INFORMATION

Payer Name: Name	Date: Date of Publication of this Template	
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Processor: Processor/Fiscal Intermediary		
Effective as of: Date the Plan will begin accepting transactions using this payer sheet	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: Date of Publication	NCPDP External Code List Version Date: Date of Publication	
Contact/Information Source: Other references such as Provider Manuals, Payer phone number, web site, etc.		
Certification Testing Window: Certification Testing Dates		
Certification Contact Information: Certification phone number and information		
Provider Relations Help Desk Info: Phone number and information		
Other versions supported: Other versions of Telecommunication Standard Supported (if applicable) and information		

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 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.0*.

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 (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		

Field #	Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill Payer Situation

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NCPDP Payer Sheet Template

Transaction Header Segment				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN NUMBER	If more than one BIN/PCN <u>but all plans use the same segments and fields and situations</u> , enter multiple BIN/PCNs under General Information above.	M	
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	
104-A4	PROCESSOR CONTROL NUMBER	Specify how this field is used, if not blanks.	M	
109-A9	TRANSACTION COUNT	Specify max # of transactions supported for each transaction code.	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Specify value supported for this plan.	M	
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Specify how this field is used, if not blanks.	M	

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

Insurance Segment Segment Identification (111-AM) = "04"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	
312-CC	CARDHOLDER FIRST NAME			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs when the cardholder has a first name.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
313-CD	CARDHOLDER LAST NAME			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
314-CE	HOME PLAN			<p><i>Imp Guide:</i> Required if needed for receiver billing/encounter validation and/or determination for Blue Cross or Blue Shield, if a Patient has coverage under more than one plan, to distinguish each plan.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
524-FO	PLAN ID			<p><i>Imp Guide:</i> Optional.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
309-C9	ELIGIBILITY CLARIFICATION CODE			<p><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.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

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	Insurance Segment Segment Identification (111-AM) = "04"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				requirement(s))
301-C1	GROUP ID			<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> (any unique payer requirement(s))
303-C3	PERSON CODE			<i>Imp Guide:</i> Required if needed to uniquely identify the family members within the Cardholder ID. <i>Payer Requirement:</i> (any unique payer requirement(s))
306-C6	PATIENT RELATIONSHIP CODE			<i>Imp Guide:</i> Required if needed to uniquely identify the relationship of the Patient to the Cardholder. <i>Payer Requirement:</i> (any unique payer requirement(s))
359-2A	MEDIGAP ID			<i>Imp Guide:</i> Required, if known, when patient has Medigap coverage. <i>Payer Requirement:</i> (any unique payer requirement(s))
360-2B	MEDICAID INDICATOR			<i>Imp Guide:</i> Required, if known, when patient has Medicaid coverage. <i>Payer Requirement:</i> (any unique payer requirement(s))
361-2D	PROVIDER ACCEPT ASSIGNMENT INDICATOR			<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement:</i> (any unique payer requirement(s))
997-G2	CMS PART D DEFINED QUALIFIED FACILITY			<i>Imp Guide:</i> Required if specified in trading partner agreement. <i>Payer Requirement:</i> (any unique payer requirement(s))
115-N5	MEDICAID ID NUMBER			<i>Imp Guide:</i> Required, if known, when patient has Medicaid coverage. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

	Patient Segment Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
331-CX	PATIENT ID QUALIFIER			<i>Imp Guide:</i> Required if Patient ID (332-CY) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))

	Patient Segment Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
332-CY	PATIENT ID			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs to validate dual eligibility.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
304-C4	DATE OF BIRTH		R	
305-C5	PATIENT GENDER CODE		R	
310-CA	PATIENT FIRST NAME			<p><i>Imp Guide:</i> Required when the patient has a first name.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS			<p><i>Imp Guide:</i> Optional.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
323-CN	PATIENT CITY ADDRESS			<p><i>Imp Guide:</i> Optional.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
324-CO	PATIENT STATE / PROVINCE ADDRESS			<p><i>Imp Guide:</i> Optional.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
325-CP	PATIENT ZIP/POSTAL ZONE			<p><i>Imp Guide:</i> Optional.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
326-CQ	PATIENT PHONE NUMBER			<p><i>Imp Guide:</i> Optional.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
307-C7	PLACE OF SERVICE			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing or patient financial responsibility.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
333-CZ	EMPLOYER ID			<p><i>Imp Guide:</i> Required if "required by law" as defined in the HIPAA final Privacy regulations section 164.501 definitions (45 CFR Parts 160 and 164 Standards for Privacy of Individually Identifiable Health Information; Final Rule - Thursday, December 28, 2000, page 82803 and following, and Wednesday, August 14, 2002, page 53267 and following.)</p> <p>Required if needed for Workers' Compensation billing.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
335-2C	PREGNANCY INDICATOR			<p><i>Imp Guide:</i> Required if pregnancy could result in different coverage, pricing or patient financial responsibility.</p>

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	Patient Segment Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Required if "required by law" as defined in the HIPAA final Privacy regulations section 164.501 definitions (45 CFR Parts 160 and 164 Standards for Privacy of Individually Identifiable Health Information; Final Rule- Thursday, December 28, 2000, page 82803 and following, and Wednesday, August 14, 2002, page 53267 and following.) <i>Payer Requirement: (any unique payer requirement(s))</i>
350-HN	PATIENT E-MAIL ADDRESS			<i>Imp Guide:</i> May be submitted for the receiver to relay patient health care communications via the Internet when provided by the patient. <i>Payer Requirement: (any unique payer requirement(s))</i>
384-4X	PATIENT RESIDENCE			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing or patient financial responsibility. <i>Payer Requirement: (any unique payer requirement(s))</i>

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) = "07"			Claim Billing/Claim Rebill
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 "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
407-D7	PRODUCT/SERVICE ID		M	
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER			<i>Imp Guide:</i> Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. <i>Payer Requirement: (any unique payer requirement(s))</i>

	Claim Segment Segment Identification (111-AM) = "07"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE			<p><i>Imp Guide:</i> Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)).</p> <p>Required if Associated Prescription/Service Reference Number (456-EN) is used.</p> <p>Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
458-SE	PROCEDURE MODIFIER CODE COUNT	Maximum count of 10.		<p><i>Imp Guide:</i> Required if Procedure Modifier Code (459-ER) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
459-ER	PROCEDURE MODIFIER CODE			<p><i>Imp Guide:</i> Required to define a further level of specificity if the Product/Service ID (407-D7) indicated a Procedure Code was submitted.</p> <p>Required if this field could result in different coverage, pricing or patient financial responsibility.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
442-E7	QUANTITY DISPENSED		R	
403-D3	FILL NUMBER		R	
405-D5	DAYS SUPPLY		R	
406-D6	COMPOUND CODE		R	
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED			<p><i>Imp Guide:</i> Required if necessary for plan benefit administration.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
419-DJ	PRESCRIPTION ORIGIN CODE			<p><i>Imp Guide:</i> Required if necessary for plan benefit administration.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.		<p><i>Imp Guide:</i> Required if Submission Clarification Code (420-DK) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

	Claim Segment Segment Identification (111-AM) = "07"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
420-DK	SUBMISSION CLARIFICATION CODE			<p><i>Imp Guide:</i> Required if clarification is needed and value submitted is greater than zero (0).</p> <p>If the Date of Service (401-D1) contains the subsequent payer coverage date, the Submission Clarification Code (420-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.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
460-ET	QUANTITY PRESCRIBED		RW	<p><i>Imp Guide:</i> ¹ 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).</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
308-C8	OTHER COVERAGE CODE			<p><i>Imp Guide:</i> Required if needed by receiver, to communicate a summation of other coverage information collected from other payers.</p> <p>Required for Coordination of Benefits.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
429-DT	SPECIAL PACKAGING INDICATOR			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing or patient financial responsibility.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER			<p><i>Imp Guide:</i> Required if Originally Prescribed Product/Service Code (455-EA) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE			<p><i>Imp Guide:</i> 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.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

¹ Clarifications that affect the Telecommunication Standard Implementation Guide Version D.0 are cited in the *Telecommunication Version D and Above Questions, Answers and Editorial Updates*.

	Claim Segment Segment Identification (111-AM) = "07"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
446-EB	ORIGINALLY PRESCRIBED QUANTITY			<p><i>Imp Guide:</i> 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.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
454-EK	SCHEDULED PRESCRIPTION ID NUMBER			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i></p>
600-28	UNIT OF MEASURE			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.</p> <p>Required if this field could result in different coverage, pricing or patient financial responsibility.</p> <p><i>Payer Requirement:</i></p>
418-DI	LEVEL OF SERVICE			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing or patient financial responsibility.</p> <p><i>Payer Requirement:</i></p>
461-EU	PRIOR AUTHORIZATION TYPE CODE			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing or patient financial responsibility.</p> <p><i>Payer Requirement:</i></p>
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing or patient financial responsibility.</p> <p><i>Payer Requirement:</i></p>
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID			<p><i>Imp Guide:</i> Required for overriding an authorized intermediary system edit when the pharmacy participates with an intermediary.</p> <p>Required if Intermediary Authorization ID (464-EX) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
464-EX	INTERMEDIARY AUTHORIZATION ID			<p><i>Imp Guide:</i> Required for overriding an authorized intermediary system edit when the pharmacy participates with an intermediary.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
343-HD	DISPENSING STATUS			<p><i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

	Claim Segment Segment Identification (111-AM) = "07"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
344-HF	QUANTITY INTENDED TO BE DISPENSED			<p><i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED			<p><i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
357-NV	DELAY REASON CODE			<p><i>Imp Guide:</i> Required when needed to specify the reason submission of the transaction has been delayed.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
391-MT	PATIENT ASSIGNMENT INDICATOR (DIRECT MEMBER REIMBURSEMENT INDICATOR)			<p><i>Imp Guide:</i> Required when the claims adjudicator does not assume the patient assigned his/her benefits to the provider or when the claims adjudicator supports a patient determination of whether he/she wants to assign or retain his/her benefits.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
995-E2	ROUTE OF ADMINISTRATION			<p><i>Imp Guide:</i> Required if specified in trading partner agreement.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
996-G1	COMPOUND TYPE			<p><i>Imp Guide:</i> Required if specified in trading partner agreement.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
147-U7	PHARMACY SERVICE TYPE			<p><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.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

Pricing Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
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
409-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED			<p><i>Imp Guide:</i> Required if its value effects the Gross Amount Due (430-DU) calculation.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
433-DX	PATIENT PAID AMOUNT SUBMITTED			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing or patient financial responsibility.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
438-E3	INCENTIVE AMOUNT SUBMITTED			<p><i>Imp Guide:</i> Required if its value effects the Gross Amount Due (430-DU) calculation.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.		<p><i>Imp Guide:</i> Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER			<p><i>Imp Guide:</i> Required if Other Amount Claimed Submitted (480-H9) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
480-H9	OTHER AMOUNT CLAIMED SUBMITTED			<p><i>Imp Guide:</i> Required if its value effects the Gross Amount Due (430-DU) calculation.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
481-HA	FLAT SALES TAX AMOUNT SUBMITTED			<p><i>Imp Guide:</i> Required if its value effects the Gross Amount Due (430-DU) calculation.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED			<p><i>Imp Guide:</i> Required if its value effects the Gross Amount Due (430-DU) calculation.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED			<p><i>Imp Guide:</i> Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used.</p> <p>Required if this field could result in different pricing.</p> <p>Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED			<p><i>Imp Guide:</i> Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used.</p> <p>Required if this field could result in different pricing.</p> <p>Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
426-DQ	USUAL AND CUSTOMARY CHARGE			<p><i>Imp Guide:</i> Required if needed per trading partner agreement.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
430-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION			<p><i>Imp Guide:</i> Required if needed for receiver claim/encounter adjudication.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

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

	Pharmacy Provider Segment Segment Identification (111-AM) = "02"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
465-EY	PROVIDER ID QUALIFIER			<p><i>Imp Guide:</i> Required if Provider ID (444-E9) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
444-E9	PROVIDER ID			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.</p> <p>Required if necessary to identify the individual responsible for dispensing of the prescription.</p> <p>Required if needed for reconciliation of encounter-reported data or encounter reporting.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

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

	Prescriber Segment Segment Identification (111-AM) = "03"			Claim Billing/Claim Rebill
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NCPDP Payer Sheet Template

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER			<p><i>Imp Guide:</i> Required if Prescriber ID (411-DB) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
411-DB	PRESCRIBER ID			<p><i>Imp Guide:</i> Required if this field could result in different coverage or patient financial responsibility.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
427-DR	PRESCRIBER LAST NAME			<p><i>Imp Guide:</i> Required when the Prescriber ID (411-DB) is not known.</p> <p>Required if needed for Prescriber ID (411-DB) validation/clarification.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
498-PM	PRESCRIBER PHONE NUMBER			<p><i>Imp Guide:</i> Required if needed for Workers' Compensation.</p> <p>Required if needed to assist in identifying the prescriber.</p> <p>Required if needed for Prior Authorization process.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER			<p><i>Imp Guide:</i> Required if Primary Care Provider ID (421-DL) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
421-DL	PRIMARY CARE PROVIDER ID			<p><i>Imp Guide:</i> Required if needed for receiver claim/encounter determination, if known and available.</p> <p>Required if this field could result in different coverage or patient financial responsibility.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
470-4E	PRIMARY CARE PROVIDER LAST NAME			<p><i>Imp Guide:</i> Required if this field is used as an alternative for Primary Care Provider ID (421-DL) when ID is not known.</p> <p>Required if needed for Primary Care Provider ID (421-DL) validation/clarification.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
364-2J	PRESCRIBER FIRST NAME			<p><i>Imp Guide:</i> Required if needed to assist in identifying the prescriber.</p>

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	Prescriber Segment Segment Identification (111-AM) = "03"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement: (any unique payer requirement(s))</i>
365-2K	PRESCRIBER STREET ADDRESS			<i>Imp Guide:</i> Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement: (any unique payer requirement(s))</i>
366-2M	PRESCRIBER CITY ADDRESS			<i>Imp Guide:</i> Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement: (any unique payer requirement(s))</i>
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS			<i>Imp Guide:</i> Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement: (any unique payer requirement(s))</i>
368-2P	PRESCRIBER ZIP/POSTAL ZONE			<i>Imp Guide:</i> Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement: (any unique payer requirement(s))</i>

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		Required only for secondary, tertiary, etc. claims.
This Segment is not supported		
Scenario 1 - Other Payer Amount Paid Repetitions Only		
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		
Additional COB Processing Information (Optional)		

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

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"			Claim Billing/Claim Rebill
				Scenario 1 - Other Payer Amount Paid Repetitions Only
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
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			<i>Imp Guide:</i> Required if Other Payer ID (340-7C) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
340-7C	OTHER PAYER ID			<i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication. <i>Payer Requirement:</i> (any unique payer requirement(s))
443-E8	OTHER PAYER DATE			<i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. <i>Payer Requirement:</i> (any unique payer requirement(s))
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.		<i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER			<i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
431-DV	OTHER PAYER AMOUNT PAID			<i>Imp Guide:</i> Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. <i>Payer Requirement:</i> (any unique payer requirement(s))
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.		<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
472-6E	OTHER PAYER REJECT CODE			<i>Imp Guide:</i> Required when the other payer has denied the payment for the billing. <i>Payer Requirement:</i> (any unique payer requirement(s))

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"			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			Imp Guide: Required if Other Payer ID (340-7C) is used. Payer Requirement: (any unique payer requirement(s))
340-7C	OTHER PAYER ID			Imp Guide: Required if identification of the Other Payer is necessary for claim/encounter adjudication. Payer Requirement: (any unique payer requirement(s))
443-E8	OTHER PAYER DATE			Imp Guide: Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. Payer Requirement: (any unique payer requirement(s))
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.		Imp Guide: Required if Other Payer Reject Code (472-6E) is used. Payer Requirement: (any unique payer requirement(s))
472-6E	OTHER PAYER REJECT CODE			Imp Guide: Required when the other payer has denied the payment for the billing. Payer Requirement: (any unique payer requirement(s))
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. Payer Requirement: (any unique payer requirement(s))
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER			Imp Guide: Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. Payer Requirement: (any unique payer requirement(s))
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. Payer Requirement: (any unique payer requirement(s))

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.		<p><i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
393-MV	BENEFIT STAGE QUALIFIER			<p><i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
394-MW	BENEFIT STAGE AMOUNT			<p><i>Imp Guide:</i> Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"				Claim Billing/Claim Rebill
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			<p><i>Imp Guide:</i> Required if Other Payer ID (340-7C) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
340-7C	OTHER PAYER ID			<p><i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
443-E8	OTHER PAYER DATE			<p><i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.		<p><i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER			<p><i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
431-DV	OTHER PAYER AMOUNT PAID			<p><i>Imp Guide:</i> Required if other payer has approved payment for some/all of the billing.</p> <p>Not used for patient financial responsibility only billing.</p> <p>Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.		<p><i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
472-6E	OTHER PAYER REJECT CODE			<p><i>Imp Guide:</i> Required when the other payer has denied the payment for the billing.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.		<p><i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER			<p><i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT			<p><i>Imp Guide:</i> Required if necessary for patient financial responsibility only billing.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p>Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.		<p><i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
393-MV	BENEFIT STAGE QUALIFIER			<p><i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
394-MW	BENEFIT STAGE AMOUNT			<p><i>Imp Guide:</i> Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

Workers' Compensation Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational		

Workers' Compensation Segment Segment Identification (111-AM) = "06"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
434-DY	DATE OF INJURY		M	
315-CF	EMPLOYER NAME			<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
316-CG	EMPLOYER STREET ADDRESS			<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
317-CH	EMPLOYER CITY ADDRESS			<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

	Workers' Compensation Segment Segment Identification (111-AM) = "06"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
318-CI	EMPLOYER STATE/PROVINCE ADDRESS			<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
319-CJ	EMPLOYER ZIP/POSTAL ZONE			<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
320-CK	EMPLOYER PHONE NUMBER			<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
321-CL	EMPLOYER CONTACT NAME			<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
327-CR	CARRIER ID			<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
435-DZ	CLAIM/REFERENCE ID			<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
117-TR	BILLING ENTITY TYPE INDICATOR		R	
118-TS	PAY TO QUALIFIER			<p><i>Imp Guide:</i> Required if Pay To ID (119-TT) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
119-TT	PAY TO ID			<p><i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
120-TU	PAY TO NAME			<p><i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
121-TV	PAY TO STREET ADDRESS			<p><i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

Workers' Compensation Segment Segment Identification (111-AM) = "06"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
122-TW	PAY TO CITY ADDRESS			<i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party. <i>Payer Requirement:</i> (any unique payer requirement(s))
123-TX	PAY TO STATE/PROVINCE ADDRESS			<i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party. <i>Payer Requirement:</i> (any unique payer requirement(s))
124-TY	PAY TO ZIP/POSTAL ZONE			<i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party. <i>Payer Requirement:</i> (any unique payer requirement(s))
125-TZ	GENERIC EQUIVALENT PRODUCT ID QUALIFIER			<i>Imp Guide:</i> Required if Generic Equivalent Product ID (126-UA) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
126-UA	GENERIC EQUIVALENT PRODUCT ID			<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

DUR/PPS Segment Segment Identification (111-AM) = "08"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.		<i>Imp Guide:</i> Required if DUR/PPS Segment is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
439-E4	REASON FOR SERVICE CODE			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. <i>Payer Requirement:</i> (any unique payer requirement(s))

DUR/PPS Segment Segment Identification (111-AM) = "08"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
440-E5	PROFESSIONAL SERVICE CODE			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.</p> <p>Required if this field affects payment for or documentation of professional pharmacy service.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
441-E6	RESULT OF SERVICE CODE			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.</p> <p>Required if this field affects payment for or documentation of professional pharmacy service.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
474-8E	DUR/PPS LEVEL OF EFFORT			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.</p> <p>Required if this field affects payment for or documentation of professional pharmacy service.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
475-J9	DUR CO-AGENT ID QUALIFIER			<p><i>Imp Guide:</i> Required if DUR Co-Agent ID (476-H6) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
476-H6	DUR CO-AGENT ID			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.</p> <p>Required if this field affects payment for or documentation of professional pharmacy service.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

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

Coupon Segment Segment Identification (111-AM) = "09"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

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	Coupon Segment Segment Identification (111-AM) = "09"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
485-KE	COUPON TYPE		M	
486-ME	COUPON NUMBER		M	
487-NE	COUPON VALUE AMOUNT			<p><i>Imp Guide:</i> Required if needed for receiver claim/encounter determination when a coupon value is known.</p> <p>Required if this field could result in different pricing and/or patient financial responsibility.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

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

	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 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER		M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST			<p><i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION			<p><i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Maximum count of 10.		<p><i>Imp Guide:</i> Required when Compound Ingredient Modifier Code (363-2H) is sent.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
363-2H	COMPOUND INGREDIENT MODIFIER CODE			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

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

	Clinical Segment Segment Identification (111-AM) = "13"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

	Clinical Segment Segment Identification (111-AM) = "13"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.		<p><i>Imp Guide:</i> Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
492-WE	DIAGNOSIS CODE QUALIFIER			<p><i>Imp Guide:</i> Required if Diagnosis Code (424-DO) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
424-DO	DIAGNOSIS CODE			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.</p> <p>Required if this field affects payment for professional pharmacy service.</p> <p>Required if this information can be used in place of prior authorization.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
493-XE	CLINICAL INFORMATION COUNTER	Maximum 5 occurrences supported.		<p><i>Imp Guide:</i> Grouped with Measurement fields (Measurement Date (494-ZE), Measurement Time (495-H1), Measurement Dimension (496-H2), Measurement Unit (497-H3), Measurement Value (499-H4)).</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
494-ZE	MEASUREMENT DATE			<p><i>Imp Guide:</i> Required if necessary when this field could result in different coverage and/or drug utilization review outcome.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
495-H1	MEASUREMENT TIME			<p><i>Imp Guide:</i> Required if Time is known or has impact on measurement.</p> <p>Required if necessary when this field could result in different coverage and/or drug utilization review outcome.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
496-H2	MEASUREMENT DIMENSION			<p><i>Imp Guide:</i> Required if Measurement Unit (497-H3) and Measurement Value (499-H4) are used.</p> <p>Required if necessary when this field could result in different coverage and/or drug utilization review outcome.</p> <p>Required if necessary for patient's weight and height when billing Medicare for a claim that includes a</p>

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

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

Additional Documentation Segment Segment Identification (111-AM) = "14"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
369-2Q	ADDITIONAL DOCUMENTATION TYPE ID		M	
374-2V	REQUEST PERIOD BEGIN DATE			<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement: (any unique payer requirement(s))</i>
375-2W	REQUEST PERIOD RECERT/REVISED DATE			<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs. Required if the Request Status (373-2U) = "2" (Revision) or "3" (Recertification). <i>Payer Requirement: (any unique payer requirement(s))</i>

	Additional Documentation Segment Segment Identification (111-AM) = "14"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
373-2U	REQUEST STATUS			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
371-2S	LENGTH OF NEED QUALIFIER			<p><i>Imp Guide:</i> Required if Length of Need (370-2R) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
370-2R	LENGTH OF NEED			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
372-2T	PRESCRIBER/SUPPLIER DATE SIGNED			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
376-2X	SUPPORTING DOCUMENTATION			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs (using Section C of Medicare's CMN forms).</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
377-2Z	QUESTION NUMBER/LETTER COUNT	Maximum count of 50.		<p><i>Imp Guide:</i> Required if needed to provide response to narratives.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
378-4B	QUESTION NUMBER/LETTER			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form.</p> <p>Required if Question Number/Letter Count (377-2Z) is greater than 0.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
379-4D	QUESTION PERCENT RESPONSE			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
380-4G	QUESTION DATE RESPONSE			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a date as the response.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
381-4H	QUESTION DOLLAR AMOUNT RESPONSE			<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a dollar amount as the response.</p>

	Additional Documentation Segment Segment Identification (111-AM) = "14"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				<i>Payer Requirement: (any unique payer requirement(s))</i>
382-4J	QUESTION NUMERIC RESPONSE			<i>Imp Guide:</i> Required if necessary for State/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a numeric as the response. <i>Payer Requirement: (any unique payer requirement(s))</i>
383-4K	QUESTION ALPHANUMERIC RESPONSE			<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires an alphanumeric as the response. <i>Payer Requirement: (any unique payer requirement(s))</i>

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

	Facility Segment Segment Identification (111-AM) = "15"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
336-8C	FACILITY ID			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. <i>Payer Requirement: (any unique payer requirement(s))</i>
385-3Q	FACILITY NAME			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. <i>Payer Requirement: (any unique payer requirement(s))</i>
386-3U	FACILITY STREET ADDRESS			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. <i>Payer Requirement: (any unique payer requirement(s))</i>
388-5J	FACILITY CITY ADDRESS			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. <i>Payer Requirement: (any unique payer requirement(s))</i>

	Facility Segment Segment Identification (111-AM) = "15"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
387-3V	FACILITY STATE/PROVINCE ADDRESS			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. <i>Payer Requirement:</i> (any unique payer requirement(s))
389-6D	FACILITY ZIP/POSTAL ZONE			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

	Narrative Segment Segment Identification (111-AM) = "16"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
390-BM	NARRATIVE MESSAGE			<i>Imp Guide:</i> Required if necessary only to support exception handling of pharmacy claims for Medicare Part B claim billing. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

4.2 RESPONSE CLAIM BILLING/CLAIM REBILL PAYER SHEET TEMPLATE

4.2.1 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: Name	Date: Date	
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:

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.0.*

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	Check	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)

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NCPDP Payer Sheet Template

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational		<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. <i>Payer Requirement:</i> (any unique payer requirement(s))

Response Insurance 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		

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
301-C1	GROUP ID			<i>Imp Guide:</i> Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available. Required to identify the actual group that was used when multiple group coverages exist. <i>Payer Requirement:</i> (any unique payer requirement(s))
524-FO	PLAN ID			<i>Imp Guide:</i> Required if needed to identify the actual plan parameters, benefit or coverage criteria, when available. Required to identify the actual plan ID that was used when multiple group coverages exist. Required if needed to contain the actual plan ID if unknown to the receiver. <i>Payer Requirement:</i> (any unique payer requirement(s))

	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			<p><i>Imp Guide:</i> Required if needed to identify the network for the covered member.</p> <p>Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available.</p> <p>Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
568-J7	PAYER ID QUALIFIER			<p><i>Imp Guide:</i> Required if Payer ID (569-J8) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
569-J8	PAYER ID			<p><i>Imp Guide:</i> Required to identify the ID of the payer responding.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
302-C2	CARDHOLDER ID			<p><i>Imp Guide:</i> Required if the identification to be used in future transactions is different than what was submitted on the request.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

Response Patient 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		

	Response Patient Segment Segment Identification (111-AM) = "29"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME			<p><i>Imp Guide:</i> Required if known.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
311-CB	PATIENT LAST NAME			<p><i>Imp Guide:</i> Required if known.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
304-C4	DATE OF BIRTH			<p><i>Imp Guide:</i> Required if known.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

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	
503-F3	AUTHORIZATION NUMBER			<i>Imp Guide:</i> Required if needed to identify the transaction. <i>Payer Requirement:</i> (any unique payer requirement(s))
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.		<i>Imp Guide:</i> Required if Approved Message Code (548-6F) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
548-6F	APPROVED MESSAGE CODE			<i>Imp Guide:</i> Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. <i>Payer Requirement:</i> (any unique payer requirement(s))
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.		<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER			<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
526-FQ	ADDITIONAL MESSAGE INFORMATION			<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement:</i> (any unique payer requirement(s))
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY			<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> (any unique payer requirement(s))
549-7F	HELP DESK PHONE NUMBER QUALIFIER			<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
550-8F	HELP DESK PHONE NUMBER			<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

Response Claim 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 <i>Imp Guide:</i> For Transaction Code of "B1" in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M
551-9F	PREFERRED PRODUCT COUNT	Maximum count of 6.	<i>Imp Guide:</i> Required if Preferred Product ID (553-AR) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
552-AP	PREFERRED PRODUCT ID QUALIFIER		<i>Imp Guide:</i> Required if Preferred Product ID (553-AR) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
553-AR	PREFERRED PRODUCT ID		<i>Imp Guide:</i> Required if a product preference exists that needs to be communicated to the receiver via an ID. <i>Payer Requirement:</i> (any unique payer requirement(s))
554-AS	PREFERRED PRODUCT INCENTIVE		<i>Imp Guide:</i> Required if there is a known incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU). <i>Payer Requirement:</i> (any unique payer requirement(s))
555-AT	PREFERRED PRODUCT COST SHARE INCENTIVE		<i>Imp Guide:</i> Required if there is a known patient financial responsibility incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU). <i>Payer Requirement:</i> (any unique payer requirement(s))
556-AU	PREFERRED PRODUCT DESCRIPTION		<i>Imp Guide:</i> 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). <i>Payer Requirement:</i> (any unique payer requirement(s))

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

Response Pricing Segment Identification (111-AM) = "23"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage Payer Situation

	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
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID			<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement. <i>Payer Requirement:</i> (any unique payer requirement(s))
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. <i>Payer Requirement:</i> (any unique payer requirement(s))
558-AW	FLAT SALES TAX AMOUNT PAID			<i>Imp Guide:</i> Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (0) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement. <i>Payer Requirement:</i> (any unique payer requirement(s))
559-AX	PERCENTAGE SALES TAX AMOUNT PAID			<i>Imp Guide:</i> 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 (0). Required if Percentage Sales Tax Rate Paid (560-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used. <i>Payer Requirement:</i> (any unique payer requirement(s))
560-AY	PERCENTAGE SALES TAX RATE PAID			<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (0). <i>Payer Requirement:</i> (any unique payer requirement(s))
561-AZ	PERCENTAGE SALES TAX BASIS PAID			<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (0). <i>Payer Requirement:</i> (any unique payer requirement(s))
521-FL	INCENTIVE AMOUNT PAID			<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement. Required if Incentive Amount Submitted (438-E3) is greater than zero (0). <i>Payer Requirement:</i> (any unique payer requirement(s))
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.		<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))

	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
564-J3	OTHER AMOUNT PAID QUALIFIER			<p><i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
565-J4	OTHER AMOUNT PAID			<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 (480-H9) is greater than zero (0).</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
566-J5	OTHER PAYER AMOUNT RECOGNIZED			<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 (0) and Coordination of Benefits/Other Payments Segment is supported.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
509-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION			<p><i>Imp Guide:</i> Required if Ingredient Cost Paid (506-F6) is greater than zero (0).</p> <p>Required if Basis of Cost Determination (432-DN) is submitted on billing.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
523-FN	AMOUNT ATTRIBUTED TO SALES TAX			<p><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.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT			<p><i>Imp Guide:</i> Provided for informational purposes only.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
513-FD	REMAINING DEDUCTIBLE AMOUNT			<p><i>Imp Guide:</i> Provided for informational purposes only.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
514-FE	REMAINING BENEFIT AMOUNT			<p><i>Imp Guide:</i> Provided for informational purposes only.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

	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
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE			<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes deductible <i>Payer Requirement:</i> (any unique payer requirement(s))
518-FI	AMOUNT OF COPAY			<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes copay as patient financial responsibility. <i>Payer Requirement:</i> (any unique payer requirement(s))
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM			<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes amount exceeding periodic benefit maximum. <i>Payer Requirement:</i> (any unique payer requirement(s))
346-HH	BASIS OF CALCULATION—DISPENSING FEE			<i>Imp Guide:</i> Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). <i>Payer Requirement:</i> (any unique payer requirement(s))
347-HJ	BASIS OF CALCULATION—COPAY			<i>Imp Guide:</i> Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). <i>Payer Requirement:</i> (any unique payer requirement(s))
348-HK	BASIS OF CALCULATION—FLAT SALES TAX			<i>Imp Guide:</i> Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill) and Flat Sales Tax Amount Paid (558-AW) is greater than zero (0). <i>Payer Requirement:</i> (any unique payer requirement(s))
349-HM	BASIS OF CALCULATION—PERCENTAGE SALES TAX			<i>Imp Guide:</i> Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill) and Percentage Sales Tax Amount Paid (559-AX) is greater than zero (0). <i>Payer Requirement:</i> (any unique payer requirement(s))
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE			<i>Imp Guide:</i> Required if the customer is responsible for 100% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay. <i>Payer Requirement:</i> (any unique payer requirement(s))
575-EQ	PATIENT SALES TAX AMOUNT			<i>Imp Guide:</i> Used when necessary to identify the Patient's portion of the Sales Tax. Provided for informational purposes only. <i>Payer Requirement:</i> (any unique payer requirement(s))

	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
574-2Y	PLAN SALES TAX AMOUNT			<p><i>Imp Guide:</i> Used when necessary to identify the Plan's portion of the Sales Tax. Provided for informational purposes only.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
572-4U	AMOUNT OF COINSURANCE			<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes coinsurance as patient financial responsibility.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
573-4V	BASIS OF CALCULATION-COINSURANCE			<p><i>Imp Guide:</i> Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill).</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.		<p><i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
393-MV	BENEFIT STAGE QUALIFIER			<p><i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
394-MW	BENEFIT STAGE AMOUNT			<p><i>Imp Guide:</i> Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
577-G3	ESTIMATED GENERIC SAVINGS			<p><i>Imp Guide:</i> This information should be provided when a patient selected the brand drug and a generic form of the drug was available. It will contain an estimate of the difference between the cost of the brand drug and the generic drug, when the brand drug is more expensive than the generic.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
128-UC	SPENDING ACCOUNT AMOUNT REMAINING			<p><i>Imp Guide:</i> This dollar amount will be provided, if known, to the receiver when the transaction had spending account dollars reported as part of the patient pay amount.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

	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
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT			<p><i>Imp Guide:</i> Required when the patient meets the plan-funded assistance criteria to reduce Patient Pay Amount (505-F5). The resulting Patient Pay Amount (505-F5) must be greater than or equal to zero.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION			<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG			<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a brand drug.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION			<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a non-preferred formulary product.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION			<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a brand non-preferred formulary product.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP			<p><i>Imp Guide:</i> Required when the patient's financial responsibility is due to the coverage gap.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
148-U8	INGREDIENT COST CONTRACTED/REIMBURSABLE AMOUNT			<p><i>Imp Guide:</i> 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.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
149-U9	DISPENSING FEE CONTRACTED/REIMBURSABLE AMOUNT			<p><i>Imp Guide:</i> 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.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

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		

	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.		<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
439-E4	REASON FOR SERVICE CODE			<i>Imp Guide:</i> Required if utilization conflict is detected. <i>Payer Requirement:</i> (any unique payer requirement(s))
528-FS	CLINICAL SIGNIFICANCE CODE			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))
529-FT	OTHER PHARMACY INDICATOR			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))
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. <i>Payer Requirement:</i> (any unique payer requirement(s))
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. <i>Payer Requirement:</i> (any unique payer requirement(s))
532-FW	DATABASE INDICATOR			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))
533-FX	OTHER PRESCRIBER INDICATOR			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))
544-FY	DUR FREE TEXT MESSAGE			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))

	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
570-NS	DUR ADDITIONAL TEXT			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))

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		

	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			<i>Imp Guide:</i> Required if Other Payer ID (340-7C) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
340-7C	OTHER PAYER ID			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> (any unique payer requirement(s))
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> (any unique payer requirement(s))
356-NU	OTHER PAYER CARDHOLDER ID			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> (any unique payer requirement(s))
992-MJ	OTHER PAYER GROUP ID			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> (any unique payer requirement(s))
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. <i>Payer Requirement:</i> (any unique payer requirement(s))

	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
127-UB	OTHER PAYER HELP DESK PHONE NUMBER			<i>Imp Guide:</i> Required if needed to provide a support telephone number of the other payer to the receiver. <i>Payer Requirement:</i> (any unique payer requirement(s))
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE			<i>Imp Guide:</i> Required if needed to uniquely identify the relationship of the patient to the cardholder ID as assigned by the other payer. <i>Payer Requirement:</i> (any unique payer requirement(s))
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE			<i>Imp Guide:</i> Required when other coverage is known which is after the Date of Service submitted. <i>Payer Requirement:</i> (any unique payer requirement(s))
145-UY	OTHER PAYER BENEFIT TERMINATION DATE			<i>Imp Guide:</i> Required when other coverage is known which is after the Date of Service submitted. <i>Payer Requirement:</i> (any unique payer requirement(s))

4.2.2 CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

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	

Field #	Response Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill Accepted/Rejected Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

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

Field #	Response Message Segment Segment Identification (111-AM) = "20"	Value	Payer Usage	Claim Billing/Claim Rebill Accepted/Rejected Payer Situation

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	Response Message Segment Segment Identification (111-AM) = "20"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE			<p><i>Imp Guide:</i> Required if text is needed for clarification or detail.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

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
301-C1	GROUP ID			<p><i>Imp Guide:</i> Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available.</p> <p>Required to identify the actual group that was used when multiple group coverages exist.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
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> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
545-2F	NETWORK REIMBURSEMENT ID			<p><i>Imp Guide:</i> Required if needed to identify the network for the covered member.</p> <p>Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available.</p> <p>Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
568-J7	PAYER ID QUALIFIER			<p><i>Imp Guide:</i> Required if Payer ID (569-J8) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
569-J8	PAYER ID			<p><i>Imp Guide:</i> Required to identify the ID of the payer responding.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

	Response Insurance Segment Segment Identification (111-AM) = "25"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID			<i>Imp Guide:</i> Required if the identification to be used in future transactions is different than what was submitted on the request. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

	Response Patient Segment Segment Identification (111-AM) = "29"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME			<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> (any unique payer requirement(s))
311-CB	PATIENT LAST NAME			<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> (any unique payer requirement(s))
304-C4	DATE OF BIRTH			<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> (any unique payer requirement(s))

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	
503-F3	AUTHORIZATION NUMBER			<i>Imp Guide:</i> Required if needed to identify the transaction. <i>Payer Requirement:</i> (any unique payer requirement(s))
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR			<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement:</i> (any unique payer requirement(s))
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.		<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER			<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
526-FQ	ADDITIONAL MESSAGE INFORMATION			<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement:</i> (any unique payer requirement(s))
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY			<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> (any unique payer requirement(s))
549-7F	HELP DESK PHONE NUMBER QUALIFIER			<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
550-8F	HELP DESK PHONE NUMBER			<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> (any unique payer requirement(s))
987-MA	URL			<i>Imp Guide:</i> Provided for informational purposes only to relay health care communications via the Internet. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

	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	<i>Imp Guide:</i> For Transaction Code of "B1" in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
551-9F	PREFERRED PRODUCT COUNT	Maximum count of 6.		<i>Imp Guide:</i> Required if Preferred Product ID (553-AR) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
552-AP	PREFERRED PRODUCT ID QUALIFIER			<i>Imp Guide:</i> Required if Preferred Product ID (553-AR) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
553-AR	PREFERRED PRODUCT ID			<i>Imp Guide:</i> Required if a product preference exists that needs to be communicated to the receiver via an ID. <i>Payer Requirement:</i> (any unique payer requirement(s))
554-AS	PREFERRED PRODUCT INCENTIVE			<i>Imp Guide:</i> Required if there is a known incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU). <i>Payer Requirement:</i> (any unique payer requirement(s))
555-AT	PREFERRED PRODUCT COST SHARE INCENTIVE			<i>Imp Guide:</i> Required if there is a known patient financial responsibility incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU). <i>Payer Requirement:</i> (any unique payer requirement(s))
556-AU	PREFERRED PRODUCT DESCRIPTION			<i>Imp Guide:</i> 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). <i>Payer Requirement:</i> (any unique payer requirement(s))

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		

	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.		<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
439-E4	REASON FOR SERVICE CODE			<i>Imp Guide:</i> Required if utilization conflict is detected. <i>Payer Requirement:</i> (any unique payer requirement(s))
528-FS	CLINICAL SIGNIFICANCE CODE			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill Accepted/Rejected
529-FT	OTHER PHARMACY INDICATOR			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))
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. <i>Payer Requirement:</i> (any unique payer requirement(s))
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. <i>Payer Requirement:</i> (any unique payer requirement(s))
532-FW	DATABASE INDICATOR			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))
533-FX	OTHER PRESCRIBER INDICATOR			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))
544-FY	DUR FREE TEXT MESSAGE			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))
570-NS	DUR ADDITIONAL TEXT			<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement:</i> (any unique payer requirement(s))

Response Prior Authorization Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational		

	Response Prior Authorization Segment Segment Identification (111-AM) = "26"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
498-PY	PRIOR AUTHORIZATION NUMBER-ASSIGNED			<i>Imp Guide:</i> Required when the receiver must submit this Prior Authorization Number in order to receive payment for the claim. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER			<i>Imp Guide:</i> Required if Other Payer ID (340-7C) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
340-7C	OTHER PAYER ID			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> (any unique payer requirement(s))
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> (any unique payer requirement(s))
356-NU	OTHER PAYER CARDHOLDER ID			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> (any unique payer requirement(s))
992-MJ	OTHER PAYER GROUP ID			<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement:</i> (any unique payer requirement(s))
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. <i>Payer Requirement:</i> (any unique payer requirement(s))
127-UB	OTHER PAYER HELP DESK PHONE NUMBER			<i>Imp Guide:</i> Required if needed to provide a support telephone number of the other payer to the receiver. <i>Payer Requirement:</i> (any unique payer requirement(s))
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE			<i>Imp Guide:</i> Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer. <i>Payer Requirement:</i> (any unique payer requirement(s))

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE			<i>Imp Guide:</i> Required when other coverage is known which is after the Date of Service submitted. <i>Payer Requirement:</i> (any unique payer requirement(s))
145-UY	OTHER PAYER BENEFIT TERMINATION DATE			<i>Imp Guide:</i> Required when other coverage is known which is after the Date of Service submitted. <i>Payer Requirement:</i> (any unique payer requirement(s))

4.2.3 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	

Field #	Response Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill Rejected/Rejected Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	R = Rejected	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

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

	Response Message Segment Segment Identification (111-AM) = "20"			Claim Billing/Claim Rebill Rejected/Rejected
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. <i>Payer Requirement:</i> (any unique payer requirement(s))

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	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
503-F3	AUTHORIZATION NUMBER			<i>Imp Guide:</i> Required if needed to identify the transaction. <i>Payer Requirement:</i> (any unique payer requirement(s))
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR			<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement:</i> (any unique payer requirement(s))
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.		<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER			<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
526-FQ	ADDITIONAL MESSAGE INFORMATION			<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement:</i> (any unique payer requirement(s))
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY			<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> (any unique payer requirement(s))
549-7F	HELP DESK PHONE NUMBER QUALIFIER			<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
550-8F	HELP DESK PHONE NUMBER			<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

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5. NCPDP VERSION D CLAIM REVERSAL INSTRUCTIONS

5.1 GENERAL INFORMATION

Fields shown in red text are to be filled out by the Payer. Fields shown in black text are not to be modified by the Payer.

Examples of payer sheet templates filled out can be found in section [“Examples of Payer Templates”](#).

5.2 REQUEST TEMPLATE INFORMATION

Sections [“Instructions to Payers”](#) and [“Field Legend”](#) must be followed.

The template information includes

- General Information
- Field Legends for Columns
- Claim Reversal Transaction (segments and fields)

5.3 RESPONSE TEMPLATE INFORMATION

The Claim Reversal response template defines the Claim Reversal response transaction for an Approved or Rejected response. Payers should fill out a separate template for each transaction supported, with each response supported, as appropriate (for example, for Claim Billing – Paid, Reject, Captured, etc response; for Service Billing – Paid, Rejected, etc response; for Reversal – Approved, Rejected, etc response) as appropriate for their business.

Sections [“Instructions to Payers”](#) and [“Field Legend”](#) must be followed.

The template information includes

- General Information
- Field Legend for Columns
- Claim Reversal Transaction Response (segments and fields)

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6. NCPDP VERSION D CLAIM REVERSAL TEMPLATE

6.1 REQUEST CLAIM REVERSAL PAYER SHEET TEMPLATE

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

GENERAL INFORMATION

Payer Name: Name	Date: Date
Plan Name/Group Name: Plan Name/Group Name	BIN: PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN: PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN: PCN:

FIELD LEGEND FOR COLUMNS

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

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

CLAIM REVERSAL TRANSACTION

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

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

Field #	Transaction Header Segment <i>NCPDP Field Name</i>	Value	Payer Usage	Claim Reversal <i>Payer Situation</i>
101-A1	BIN NUMBER	If more than one BIN/PCN <u>but all plans use the same segments and fields and situations</u> , enter multiple BIN/PCNs under General Information above.	M	
102-A2	VERSION/RELEASE NUMBER	DO	M	
103-A3	TRANSACTION CODE	B2	M	
104-A4	PROCESSOR CONTROL NUMBER	Specify how this field is used, if not blanks.	M	

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NCPDP Payer Sheet Template

Transaction Header Segment				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
109-A9	TRANSACTION COUNT	Specify max # of transactions supported for each transaction code.	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Specify value supported for this plan.	M	
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Specify how this field is used, if not blanks.	M	

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

Insurance Segment Segment Identification (111-AM) = "04"				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	
301-C1	GROUP ID			Imp Guide: Required if needed to match the reversal to the original billing transaction. Payer Requirement: (any unique payer requirement(s))
359-2A	MEDIGAP ID			Imp Guide: Required, if known, when patient has Medigap coverage. Payer Requirement: (any unique payer requirement(s))

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

Claim Segment Segment Identification (111-AM) = "07"				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER		M	Imp Guide: For Transaction Code of "B2", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
407-D7	PRODUCT/SERVICE ID		M	
403-D3	FILL NUMBER			Imp Guide: Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (402-D2) occur on the same day. Payer Requirement: (any unique payer requirement(s))
308-C8	OTHER COVERAGE CODE			Imp Guide: Required if needed by receiver to match the claim that is being reversed. Payer Requirement: (any unique payer requirement(s))

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	Claim Segment Segment Identification (111-AM) = "07"			Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
147-U7	PHARMACY SERVICE TYPE			<i>Imp Guide:</i> Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
438-E3	INCENTIVE AMOUNT SUBMITTED			<i>Imp Guide:</i> Required if this field could result in contractually agreed upon payment. <i>Payer Requirement:</i> (any unique payer requirement(s))
430-DU	GROSS AMOUNT DUE			<i>Imp Guide:</i> Required if this field could result in contractually agreed upon payment. <i>Payer Requirement:</i> (any unique payer requirement(s))

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent		
This Segment is situational		

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"			Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	

DUR/PPS Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent		
This Segment is situational		

	DUR/PPS Segment Segment Identification (111-AM) = "08"			Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.		<i>Imp Guide:</i> Required if DUR/PPS Segment is used. <i>Payer Requirement:</i> (any unique payer requirement(s))

	DUR/PPS Segment Segment Identification (111-AM) = "08"			Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
439-E4	REASON FOR SERVICE CODE			Imp Guide: Required if this field is needed to report drug utilization review outcome. Payer Requirement: (any unique payer requirement(s))
440-E5	PROFESSIONAL SERVICE CODE			Imp Guide: Required if this field is needed to report drug utilization review outcome. Payer Requirement: (any unique payer requirement(s))
441-E6	RESULT OF SERVICE CODE			Imp Guide: Required if this field is needed to report drug utilization review outcome. Payer Requirement: (any unique payer requirement(s))
474-8E	DUR/PPS LEVEL OF EFFORT			Imp Guide: Required if this field is needed to report drug utilization review outcome. Payer Requirement: (any unique payer requirement(s))

** End of Request Claim Reversal (B2) Payer Sheet Template**

6.2 RESPONSE CLAIM REVERSAL PAYER SHEET TEMPLATE

6.2.1 CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

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

GENERAL INFORMATION

Payer Name:	Date:		
Plan Name/Group Name: Plan Name/Group Name	BIN:		PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:		PCN:

CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

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

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

Field #	Response Transaction Header Segment 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	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

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

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	Response Message Segment Segment Identification (111-AM) = "20"			Claim Reversal – Accepted/Approved
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. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	
503-F3	AUTHORIZATION NUMBER			<i>Imp Guide:</i> Required if needed to identify the transaction. <i>Payer Requirement:</i> (any unique payer requirement(s))
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.		<i>Imp Guide:</i> Required if Approved Message Code (548-6F) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
548-6F	APPROVED MESSAGE CODE			<i>Imp Guide:</i> Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. <i>Payer Requirement:</i> (any unique payer requirement(s))
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.		<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER			<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
526-FQ	ADDITIONAL MESSAGE INFORMATION			<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement:</i> (any unique payer requirement(s))
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY			<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> (any unique payer requirement(s))

Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
549-7F	HELP DESK PHONE NUMBER QUALIFIER			<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
550-8F	HELP DESK PHONE NUMBER			<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

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

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

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

6.2.2 CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

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

Response Transaction Header Segment				Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	

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Response Transaction Header Segment				Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

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

Response Message Segment Segment Identification (111-AM) = "20"				Claim Reversal – Accepted/Rejected
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. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

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

Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY			<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> (any unique payer requirement(s))
549-7F	HELP DESK PHONE NUMBER QUALIFIER			<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
550-8F	HELP DESK PHONE NUMBER			<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

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

6.2.3 CLAIM REVERSAL REJECTED/REJECTED RESPONSE

CLAIM REVERSAL REJECTED/REJECTED RESPONSE

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

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

	Response Message Segment Segment Identification (111-AM) = "20"			Claim Reversal – Rejected/Rejected
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. <i>Payer Requirement:</i> (any unique payer requirement(s))

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

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR			<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement:</i> (any unique payer requirement(s))
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.		<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER			<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
526-FQ	ADDITIONAL MESSAGE INFORMATION			<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement:</i> (any unique payer requirement(s))
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY			<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> (any unique payer requirement(s))
549-7F	HELP DESK PHONE NUMBER QUALIFIER			<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
550-8F	HELP DESK PHONE NUMBER			<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> (any unique payer requirement(s))

** End of Claim Reversal (B2) Response Payer Sheet Template**

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7. EXAMPLES OF PAYER TEMPLATES

These examples should not be taken as real examples but rather to show a Payer how to fill out the various sections and columns. Each section that follows is viewed as a payer relaying their plan requirements for request and response data. These examples do not include "Additional Information," "Certification Requirements" or "Test Data" sections of the Payer template.

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8. EXAMPLE 1 – HEALTH PLAN OF AMERICA PAYER SHEET – ONE PLAN

Claim Bill/Claim Rebill and Reversal Template for One Plan

This is an example of a prepared payer sheet for one plan. The payer sheet shows how this payer would expect to receive a standard request and how the payer would respond. This plan accepts Claim Billing/Claim Rebill transactions and Claim Reversal transactions. The plan does not participate in Medicare Part D processing. The payer sheet shows paid and a rejected response for the Claim Billing/Claim Rebill and approved and rejected responses for the Claim Reversal. Since the plan supports other transactions besides Claim Billing/Claim Rebill and Claim Reversal transactions, other payer sheet sections would be created for each transaction request and response. They are not shown in this example.

[Claim Billing/Claim Rebill Request](#)

[Claim Billing/Claim Rebill Accepted/Paid Response](#)

[Claim Billing/Claim Rebill Accepted/Rejected Response](#)

[Claim Billing/Claim Rebill Rejected/Rejected Response](#)

[Claim Reversal Request](#)

[Claim Reversal Accepted/Approved Response](#)

[Claim Reversal Accepted/Rejected Response](#)

[Claim Reversal Rejected/Rejected Response](#)

8.1.1 CLAIM BILLING/CLAIM REBILL

8.1.1.1 CLAIM BILLING/CLAIM REBILL REQUEST

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

GENERAL INFORMATION

Payer Name: Payers Unlimited	Date: 01/01/2010
Plan Name/Group Name: Health Plan of America	BIN: 669988 PCN: Blank fill
Processor:	
Effective as of: 07/01/2010	NCPDP Telecommunication Standard Version/Release #: D.0
NCPDP Data Dictionary Version Date: 07/2007	NCPDP External Code List Version Date: 01/2008
Contact/Information Source: Provider Manuals available at www.healthplan.com/provmanual, General website www.healthplan.com	
Certification Testing Window: Monday-Friday 8 am ET – 5 pm ET	
Certification Contact Information: 888-111-3333 Certification packet available	
Provider Relations Help Desk Info: Pharmacy Help Desk: 888-111-2222 Physician Help Desk: 888-111-4444	
Other versions supported:	

OTHER TRANSACTIONS SUPPORTED

Transaction Code	Transaction Name
B2	Claim Reversal
S1	Service Billing
S2	Service Reversal
S3	Service Rebill
E1	Eligibility Verification
D1	Predetermination of Benefits

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 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.

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CLAIM BILLING/CLAIM REBILL TRANSACTION

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 (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	X	

Field #	Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill Payer Situation
101-A1	BIN NUMBER	669988	M	BIN for Health Plan of America
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	Claim Billing, Claim Rebill
104-A4	PROCESSOR CONTROL NUMBER	Blank fill	M	Blank fill
109-A9	TRANSACTION COUNT	01 = One occurrence	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M	
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill

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

Field #	Insurance Segment Segment Identification (111-AM) = "04"	Value	Payer Usage	Claim Billing/Claim Rebill Payer Situation
302-C2	CARDHOLDER ID		M	Member's ID as shown on card.
303-C3	PERSON CODE		RW	Imp Guide: Required if needed to uniquely identify the family members within the Cardholder ID. Payer Requirement: This information is located at the end of the Cardholder ID on the Benefit Card.
306-C8	PATIENT RELATIONSHIP CODE	All values supported	RW	Imp Guide: Required if needed to uniquely identify the relationship of the Patient to the Cardholder. Payer Requirement: Required.
301-C1	GROUP ID		RW	Imp Guide: Required if necessary for state/federal/regulatory agency programs. Required if needed for pharmacy claim processing and payment Payer Requirement: Required.

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

Field	Patient Segment Segment Identification (111-AM) = "01"	Value	Payer Usage	Claim Billing/Claim Rebill Payer Situation
304-C4	DATE OF BIRTH		R	

	Patient Segment Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
305-C5	PATIENT GENDER CODE	All code set values supported	R	
310-CA	PATIENT FIRST NAME		RW	Imp Guide: Required when the patient has a first name. Payer Requirement: Required as all patients are enrolled with a first name. If newborn, use "BABY BOY" or "BABY GIRL." If person has only one name, put one name in this field.
311-CB	PATIENT LAST NAME		R	
307-C7	PLACE OF SERVICE	13 = Assisted Living Facility 31 = Skilled Nursing Facility 32 = Nursing Facility	RW	Imp Guide: Required if this field could result in different coverage, pricing or patient financial responsibility. Payer Requirement: Required for values listed.

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	X	

	Claim Segment Segment Identification (111-AM) = "07"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	Claim Billing Imp Guide: For Transaction Code of "B1" or "B3", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing)
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	01 = Universal Product Code (UPC) 03 = National Drug Code (NDC)	M	
407-D7	PRODUCT/SERVICE ID		M	
442-E7	QUANTITY DISPENSED		R	
403-D3	FILL NUMBER		R	
405-D5	DAYS SUPPLY		R	
406-D6	COMPOUND CODE	01 = Not a Compound 02 = Compound See Compound Segment for support of multi-ingredient compounds	R	
408-D8	DISPENSE AS WRITTEN (DAW/PRODUCT SELECTION CODE)	All values supported	R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	Imp Guide: Required if Submission Clarification Code (420-DK) is used. Payer Requirement: Same as Imp Guide.

	Claim Segment Segment Identification (111-AM) = "07"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
420-DK	SUBMISSION CLARIFICATION CODE	All values supported	RW	<p><i>Imp Guide:</i> Required if clarification is needed and value submitted is greater than zero (0).</p> <p>If the Date of Service (401-D1) contains the subsequent payer coverage date, the Submission Clarification Code (420-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.</p> <p><i>Payer Requirement:</i> Required when further explanation is needed for overrides.</p>
308-C8	OTHER COVERAGE CODE	<p>1 = No other coverage</p> <p>2 = Other coverage exists – payment collected</p> <p>3 = Other coverage billed – claim not covered</p> <p>4 = Other coverage exists-payment not collected</p>	RW	<p><i>Imp Guide:</i> Required if needed by receiver, to communicate a summation of other coverage information collected from other payers.</p> <p>Required for Coordination of Benefits.</p> <p><i>Payer Requirement:</i> Only used in COB processing.</p>
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	<p>01 = Universal Product Code (UPC)</p> <p>03 = National Drug Code (NDC)</p>	RW	<p><i>Imp Guide:</i> Required if Originally Prescribed Product/Service Code (455-EA) is used.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE		RW	<p><i>Imp Guide:</i> 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.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
446-EB	ORIGINALLY PRESCRIBED QUANTITY		RW	<p><i>Imp Guide:</i> 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.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
995-E2	ROUTE OF ADMINISTRATION		RW	<p><i>Imp Guide:</i> Required if specified in trading partner agreement.</p> <p><i>Payer Requirement:</i> Required when Compound Code (406-D6) = 2 (compound).</p>

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

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	INGREDIENT COST SUBMITTED		R	
430-DU	GROSS AMOUNT DUE		R	
412-DC	DISPENSING FEE SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (430-DU) calculation.

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Pricing Segment Segment Identification (111-AM) = "11"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				<i>Payer Requirement: Same as Imp Guide.</i>
426-DQ	USUAL AND CUSTOMARY CHARGE		RW	<i>Imp Guide:</i> Required if needed per trading partner agreement. <i>Payer Requirement: Required.</i>
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.		<i>Imp Guide:</i> Required if Other Amount Claimed Submitted Qualifier (479-H8) is used. <i>Payer Requirement: Same as Imp Guide.</i>
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER			<i>Imp Guide:</i> Required if Other Amount Claimed Submitted (480-H9) is used. <i>Payer Requirement: Same as Imp Guide.</i>
480-H9	OTHER AMOUNT CLAIMED SUBMITTED			<i>Imp Guide:</i> Required if its value effects the Gross Amount Due (430-DU) calculation. <i>Payer Requirement: Same as Imp Guide.</i>
423-DN	BASIS OF COST DETERMINATION	01 = AWP 06 = MAC 07 = Usual & Customary	RW	<i>Imp Guide:</i> Required if needed for receiver claim/encounter adjudication. <i>Payer Requirement: Support of values shown.</i>

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	<i>Required only for secondary, tertiary, etc. claims.</i>
Scenario 1 - Other Payer Amount Paid Repetitions Only	X	
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount and Benefit Stage Repetitions Present (Government Programs)		

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Scenario 1 - Other Payer Amount Paid Repetitions Only
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE	All values supported	M	
339-6C	OTHER PAYER ID QUALIFIER	03 = BIN	RW	<i>Imp Guide:</i> Required if Other Payer ID (340-7C) is used. <i>Payer Requirement: Only value supported.</i>
340-7C	OTHER PAYER ID		RW	<i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication. <i>Payer Requirement: Same as Imp Guide.</i>
443-E8	OTHER PAYER DATE		RW	<i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. <i>Payer Requirement: Same as Imp Guide.</i>
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				<i>Payer Requirement: Same as Imp Guide.</i>
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	All values supported	RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used. <i>Payer Requirement: Same as Imp Guide.</i>
431-DV	OTHER PAYER AMOUNT PAID		RW	<i>Imp Guide:</i> Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. <i>Payer Requirement: Same as Imp Guide.</i>
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used. <i>Payer Requirement: See above</i>
472-6E	OTHER PAYER REJECT CODE	NCPDP Reject Codes	RW	<i>Imp Guide:</i> Required when the other payer has denied the payment for the billing. <i>Payer Requirement: Same as Imp Guide.</i>

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

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	All values supported	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	All values supported	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum of 25 ingredients.	M	<i>Payer Requirement: Maximum of 10 ingredients.</i>
488-RE	COMPOUND PRODUCT ID QUALIFIER	01 = Universal Product Code (UPC) 03 = National Drug Code (NDC)	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		RW	<i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed. <i>Payer Requirement: Required for each ingredient.</i>

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

8.1.1.2 CLAIM BILLING/CLAIM REBILL ACCEPTED/PAID (OR DUPLICATE OF PAID)

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RESPONSE

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

GENERAL INFORMATION

Payer Name: Payers Unlimited	Date: 01/01/2010
Plan Name/Group Name: Health Plan of America	BIN: 669988 PCN: Blank fill

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	X	

Field #	Response Transaction Header Segment <i>NCPDP Field Name</i>	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) <i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	Claim Billing, Claim Rebill
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 Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

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

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	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		RW	<p><i>Imp Guide:</i> Required if needed to identify the network for the covered member.</p> <p>Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available.</p> <p>Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist.</p> <p><i>Payer Requirement:</i> Will be returned.</p>

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
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	
503-F3	AUTHORIZATION NUMBER		RW	<p><i>Imp Guide:</i> Required if needed to identify the transaction.</p> <p><i>Payer Requirement:</i> Will contain the traceback number of the claim.</p>
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<p><i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.</p> <p><i>Payer Requirement:</i> Maximum count of 2 will be returned.</p>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	<p>01 = Used for first line of free form text with no pre-defined structure.</p> <p>02 = Used for second line of free form text with no pre-defined structure.</p>	RW	<p><i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.</p> <p><i>Payer Requirement:</i> Only qualifier values cited will be returned.</p>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<p><i>Imp Guide:</i> Required when additional text is needed for clarification or detail.</p> <p><i>Payer Requirement:</i> Will be returned.</p>
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<p><i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used.</p> <p><i>Payer Requirement:</i> Will be returned.</p>
550-8F	HELP DESK PHONE NUMBER		RW	<p><i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.</p> <p><i>Payer Requirement:</i> Will be returned.</p>

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
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" or "B3", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response 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
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID		RW	Imp Guide: Required if this value is used to arrive at the final reimbursement. Payer Requirement: Same as Imp 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 Imp Guide.
558-AW	FLAT SALES TAX AMOUNT PAID		RW	Imp Guide: Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (0) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement. Payer Requirement: Same as Imp 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 (0). Required if Percentage Sales Tax Rate Paid (560-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used. Payer Requirement: Same as Imp Guide.
560-AY	PERCENTAGE SALES TAX RATE PAID		RW	Imp Guide: Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (0). Payer Requirement: Same as Imp Guide.
561-AZ	PERCENTAGE SALES TAX BASIS PAID		RW	Imp Guide: Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (0). Payer Requirement: Same as Imp 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 (0). Payer Requirement: Same as Imp Guide.

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	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
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used. <i>Payer Requirement: Will be returned when submission includes Other Amount Claimed Submitted.</i>
564-J3	OTHER AMOUNT PAID QUALIFIER	All values supported	RW	<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used. <i>Payer Requirement: Will be returned when submission includes Other Amount Claimed Submitted.</i>
565-J4	OTHER AMOUNT PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement. Required if Other Amount Claimed Submitted (480-H9) is greater than zero (0). <i>Payer Requirement: Will be returned when submission includes Other Amount Claimed Submitted.</i>
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement. Required if Other Payer Amount Paid (431-DV) is greater than zero (0) and Coordination of Benefits/Other Payments Segment is supported. <i>Payer Requirement: Same as Imp Guide.</i>
509-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	3 = Ingredient Cost Reduced to AWP Less X% Pricing 4 = Usual & Customary Paid as Submitted 6 = MAC Pricing Ingredient Cost Paid 15 = Patient Pay Amount	RW	<i>Imp Guide:</i> Required if Ingredient Cost Paid (506-F6) is greater than zero (0). Required if Basis of Cost Determination (432-DN) is submitted on billing. <i>Payer Requirement: Same as Imp Guide.</i>
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes deductible <i>Payer Requirement: Same as Imp Guide.</i>
572-4U	AMOUNT OF COINSURANCE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes coinsurance as patient financial responsibility. <i>Payer Requirement: Same as Imp Guide.</i>
575-EQ	PATIENT SALES TAX AMOUNT		RW	<i>Imp Guide:</i> Used when necessary to identify the Patient's portion of the Sales Tax. <i>Payer Requirement: Same as Imp Guide.</i>
574-2Y	PLAN SALES TAX AMOUNT		RW	<i>Imp Guide:</i> Used when necessary to identify the Plan's portion of the Sales Tax. Provided for informational purposes only. <i>Payer Requirement: Same as Imp Guide.</i>

	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
577-G3	ESTIMATED GENERIC SAVINGS		RW	<p><i>Imp Guide:</i> This information should be provided when a patient selected the brand drug and a generic form of the drug was available. It will contain an estimate of the difference between the cost of the brand drug and the generic drug, when the brand drug is more expensive than the generic.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
128-UC	SPENDING ACCOUNT AMOUNT REMAINING		RW	<p><i>Imp Guide:</i> This dollar amount will be provided, if known, to the receiver when the transaction had spending account dollars reported as part of the patient pay amount.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT		RW	<p><i>Imp Guide:</i> Required when the patient meets the plan-funded assistance criteria, to reduce Patient Pay Amount (505-F5). The resulting Patient Pay Amount (505-F5) must be greater than or equal to zero.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG		RW	<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a Brand drug.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION		RW	<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a non-preferred formulary product.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION		RW	<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a Brand non-preferred formulary product.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
148-U8	INGREDIENT COST CONTRACTED/REIMBURSABLE AMOUNT		RW	<p><i>Imp Guide:</i> 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.</p> <p><i>Payer Requirement:</i> Required when Basis of Reimbursement Determination (522-FM) is "15" (Patient Pay Amount).</p>
149-U9	DISPENSING FEE CONTRACTED/REIMBURSABLE AMOUNT		RW	<p><i>Imp Guide:</i> 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</p> <p><i>Payer Requirement:</i> Required when Basis of Reimbursement Determination (522-FM) is "15" (Patient Pay Amount).</p>

8.1.1.3 CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

CLAIM BILLING/CLAIM REBILL 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 #	Response Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Rejected Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	Claim Billing, Claim Rebill
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Will be returned on rejected claims when the error is at transmission-level.</i>

Field #	Response Message Segment Segment Identification (111-AM) = "20"	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Rejected Payer Situation
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail. <i>Payer Requirement:</i> Will be returned when text information needs to be sent.

Response Patient Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Will be returned if patient can be found</i>

Field #	Response Patient Segment Segment Identification (111-AM) = "29"	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Rejected Payer Situation
310-CA	PATIENT FIRST NAME		RW	<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> Will be returned if patient can be found.
311-CB	PATIENT LAST NAME		RW	<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> Will be returned if patient can be found.
304-C4	DATE OF BIRTH		RW	<i>Imp Guide:</i> Required if known. <i>Payer Requirement:</i> Will be returned if patient can be found.

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/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 – Accepted/Rejected

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NCPDP Payer Sheet Template

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	NCPDP Reject Codes	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement: Same as Imp Guide.</i>
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement: Maximum count of 2 will be returned.</i>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	01 = Used for first line of free form text with no pre-defined structure. 02 = Used for second line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement: Only qualifier values cited will be returned.</i>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement: Will be returned.</i>
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement: Will be returned.</i>
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement: Will be returned.</i>
987-MA	URL		RW	<i>Imp Guide:</i> Provided for informational purposes only to relay health care communications via the Internet. <i>Payer Requirement: Will be returned when the link may provide guidance to the receiver.</i>

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

Field #	Response Claim Segment Segment Identification (111-AM) = "22"	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Rejected <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	
551-9F	PREFERRED PRODUCT COUNT		Maximum count of 6.	RW	<i>Imp Guide:</i> Required if Preferred Product ID (553-AR) is used. <i>Payer Requirement: Same as Imp Guide.</i>
552-AP	PREFERRED PRODUCT ID QUALIFIER		03 = National Drug Code (NDC)	RW	<i>Imp Guide:</i> Required if Preferred Product ID (553-AR) is used. <i>Payer Requirement: Same as Imp Guide.</i>

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Billing/Claim Rebill – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
553-AR	PREFERRED PRODUCT ID		RW	<i>Imp Guide:</i> Required if a product preference exists that needs to be communicated to the receiver via an ID. <i>Payer Requirement: Same as Imp Guide.</i>
554-AS	PREFERRED PRODUCT INCENTIVE		RW	<i>Imp Guide:</i> Required if there is a known incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU). <i>Payer Requirement: Same as Imp Guide.</i>
555-AT	PREFERRED PRODUCT COST SHARE INCENTIVE		RW	<i>Imp Guide:</i> Required if there is a known patient financial responsibility incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU). <i>Payer Requirement: Same as Imp Guide.</i>
556-AU	PREFERRED PRODUCT DESCRIPTION		RW	<i>Imp Guide:</i> 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). <i>Payer Requirement: Same as Imp Guide.</i>

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	<i>This segment will be transmitted on a reject when a possible conflict is detected.</i>

	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	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used. <i>Payer Requirement: Same as Imp Guide.</i>
439-E4	REASON FOR SERVICE CODE	All values supported.	RW	<i>Imp Guide:</i> Required if utilization conflict is detected. <i>Payer Requirement: Same as Imp Guide.</i>
528-FS	CLINICAL SIGNIFICANCE CODE	All values supported.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement: Same as Imp Guide.</i>
529-FT	OTHER PHARMACY INDICATOR	All values supported.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement: Same as Imp Guide.</i>
530-FU	PREVIOUS DATE OF FILL		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. <i>Payer Requirement: Same as Imp Guide.</i>

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
531-FV	QUANTITY OF PREVIOUS FILL		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (530-FU) is used. <i>Payer Requirement: Same as Imp Guide.</i>
532-FW	DATABASE INDICATOR	All values supported.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement: Same as Imp Guide.</i>
533-FX	OTHER PRESCRIBER INDICATOR	All values supported.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement: Same as Imp Guide.</i>
544-FY	DUR FREE TEXT MESSAGE		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement: Same as Imp Guide.</i>
570-NS	DUR ADDITIONAL TEXT		RW	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used. <i>Payer Requirement: Same as Imp Guide.</i>

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Will be sent if other payers known.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Claim Billing/Claim Rebill – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE	All values supported.	M	
339-6C	OTHER PAYER ID QUALIFIER	03 = BIN	RW	<i>Imp Guide:</i> Required if Other Payer ID (340-7C) is used. <i>Payer Requirement: Same as Imp Guide.</i>
340-7C	OTHER PAYER ID		RW	<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement: Same as Imp Guide.</i>
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement: Same as Imp Guide.</i>
356-NU	OTHER PAYER CARDHOLDER ID		RW	<i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits. <i>Payer Requirement: Same as Imp Guide.</i>

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

8.1.1.4 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 <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

Field #	Response Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Rejected/Rejected Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	Claim Billing, Claim Rebill
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected <i>If Situational, Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Will be returned on rejected claims when the error is at transmission-level.</i>

	Response Message Segment Segment Identification (111-AM) = "20"			Claim Billing/Claim Rebill – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail. <i>Payer Requirement:</i> Will be returned when text information needs to be sent.

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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
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Reject Codes	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement: Same as Imp Guide.</i>
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement: Maximum count of 2 will be returned.</i>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	01 = Used for first line of free form text with no pre-defined structure. 02 = Used for second line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement: Only qualifier values cited will be returned.</i>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail. <i>Payer Requirement: Will be returned.</i>
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement: Will be returned.</i>
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement: Will be returned.</i>

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

8.1.2 CLAIM REVERSAL

Same plan - continuation of the example of a payer sheet with information about claims reversals. The payer sheet shows an approved and a rejected response.

- [Claim Reversal Request](#)
- [Claim Reversal Accepted/Approved](#)
- [Claim Reversal Accepted/Rejected](#)
- [Claim Reversal Rejected/Rejected](#)

8.1.2.1 CLAIM REVERSAL REQUEST

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

GENERAL INFORMATION

Payer Name: Payers Unlimited	Date: 01/01/2010
Plan Name/Group Name: Health Plan of America	BIN: 669988 PCN: Blank fill

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

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Payer Usage Column	Value	Explanation	Payer Situation Column
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

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

CLAIM REVERSAL TRANSACTION

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

Field #	Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Reversal Payer Situation
101-A1	BIN NUMBER	669988	M	BIN for Health Plan of America
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	Claim Reversal
104-A4	PROCESSOR CONTROL NUMBER	Blank fill	M	Blank fill
109-A9	TRANSACTION COUNT	01 = One occurrence	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M	
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill

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

Field #	Insurance Segment Segment Identification (111-AM) = "04"	Value	Payer Usage	Claim Reversal Payer Situation
302-C2	CARDHOLDER ID		M	Member's ID as shown on card.
301-C1	GROUP ID		RW	Imp Guide: Required if needed to match the reversal to the original billing transaction. Payer Requirement: Required.

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

Field #	Claim Segment Segment Identification (111-AM) = "07"	Value	Payer Usage	Claim Reversal Payer Situation
	NCPDP Field Name			

Claim Segment Segment Identification (111-AM) = "07"				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).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	01 = Universal Product Code (UPC) 03 = National Drug Code (NDC)	M	
407-D7	PRODUCT/SERVICE ID		M	
403-D3	FILL NUMBER		RW	<i>Imp Guide:</i> Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (402-D2) occur on the same day. <i>Payer Requirement:</i> Same as Imp Guide.
308-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.

** End of Request Claim Reversal (B2) Payer Sheet Template**

8.1.2.2 CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

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

GENERAL INFORMATION

Payer Name: Payers Unlimited	Date: 01/01/2010	
Plan Name/Group Name: Health Plan of America	BIN: 669988	PCN: Blank fill

CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

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

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

Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	

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Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Maximum count of 2 will be returned.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	01 = Used for first line of free form text with no pre-defined structure. 02 = Used for second line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Only qualifier values cited will be returned.
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.

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

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

8.1.2.3 CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

CLAIM REVERSL ACCEPTED/REJECTED RESPONSE

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

Transaction Header Segment				Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	Claim Reversal
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	

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NCPDP Payer Sheet Template

Transaction Header Segment				Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request 01 = 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.

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

Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Reject Codes	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement:</i> Same as Imp Guide.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Maximum count of 2 will be returned.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	01 = Used for first line of free form text with no pre-defined structure. 02 = Used for second line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Only qualifier values cited will be returned.
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.

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

Field #	Response Claim Segment Segment Identification (111-AM) = "22"	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).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER			M	

8.1.2.4 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 #	Transaction Header Segment	NCPDP Field Name	Value	Payer Usage	Claim Reversal – Rejected/Rejected 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		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 #	Response Message Segment Segment Identification (111-AM) = "20"	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 #	Response Status Segment Segment Identification (111-AM) = "21"	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		NCPDP Reject Codes	R	

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Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement:</i> Same as Imp Guide.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Maximum count of 2 will be returned.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	01 = Used for first line of free form text with no pre-defined structure. 02 = Used for second line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Only qualifier values cited will be returned.
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.

** End of Claim Reversal (B2) Response Payer Sheet Template**

9. EXAMPLE 2 – HEALTH SERVICE OF AMERICA PAYER SHEET - SERVICE

Service Billing Template for One Plan

This is an example of a prepared payer sheet for one plan that does not support service rebill transactions (S3). This plan only accepts service billing transactions (S1). The payer sheet shows how this payer would expect to receive a standard request and how the payer would respond. The plan does not participate in Medicare Part D processing. The payer sheet shows a paid and a rejected response. Since the plan supports other transactions besides Service Billing, other payer sheet sections would be created for each transaction request and response. They are not shown in this excerpted example.

[Service Billing Request](#)

[Service Billing Accepted/Paid Response](#)

[Service Billing Accepted/Rejected Response](#)

[Service Billing Rejected/Rejected Response](#)

9.1.1 SERVICE BILLING

9.1.1.1 SERVICE BILLING REQUEST

**** Start of Service Billing Request (S1) Payer Sheet Template****

GENERAL INFORMATION

Payer Name: Services Unlimited	Date: 01/01/2024	
Plan Name/Group Name: Health Service of America	BIN: 111111	PCN: SERV
Processor:		
Effective as of: 07/01/2024	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: 07/2007	NCPDP External Code List Version Date: 10/01/2023	
Contact/Information Source: Provider Manuals available at www.healthserviceamerica.org/pharmacy General website www.healthserviceamerica.org		
Certification Testing Window:		
Certification Contact Information: none required		
Provider Relations Help Desk Info: Pharmacy Help Desk: 877-111-2222 Physician Help Desk: 888-111-3333		
Other versions supported:		

OTHER TRANSACTIONS SUPPORTED

Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal
E1	Eligibility Verification
D1	Predetermination of Benefits

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 not used in the Service Billing transaction and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

SERVICE BILLING TRANSACTION

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

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NCPDP Payer Sheet Template

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	X	

Transaction Header Segment				Service Billing	Comment
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation	
101-A1	BIN NUMBER	111111	M	BIN for Health Service of America	
102-A2	VERSION/RELEASE NUMBER	D0	M		
103-A3	TRANSACTION CODE	S1	M	Service Billing	
104-A4	PROCESSOR CONTROL NUMBER	SERV	M		
109-A9	TRANSACTION COUNT	01 = One occurrence 02 = Two occurrences 03 = Three occurrences 04 = Four occurrences	M		Recommendation is to only send a transaction count of 1 to align with the next named HIPAA-named version
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M		
201-B1	SERVICE PROVIDER ID		M		
401-D1	DATE OF SERVICE		M		
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill	

Insurance Segment Questions	Check	Service Billing If Situational, Payer Situation
This Segment is always sent	X	

Insurance Segment Segment Identification (111-AM) = "04"				Service Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	Member's ID as shown on card.
303-C3	PERSON CODE		RW	Imp Guide: Required if needed to uniquely identify the family members within the Cardholder ID. Payer Requirement: Required. This information is located at the end of the Cardholder ID on the patient's ID card and/or an E1 response.
301-C1	GROUP ID		RW	Imp Guide: Required if necessary for state/federal/regulatory agency programs. Required if needed for pharmacy claim processing and payment Payer Requirement: Required. This information is located on the patient's ID card and/or an E1 response.

Patient Segment Questions	Check	Service Billing If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Patient Segment Segment Identification (111-AM) = "01"				Service Billing
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
304-C4	DATE OF BIRTH		R	
305-C5	PATIENT GENDER CODE		R	
310-CA	PATIENT FIRST NAME		RW	Imp Guide: Required when the patient has a first name. Payer Requirement: Same as Imp Guide

	Patient Segment Segment Identification (111-AM) = "01"			Service Billing
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
311-CB	PATIENT LAST NAME		R	
307-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> Required to indicate the setting in which the service was provided.
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> Required.

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

	Claim Segment Segment Identification (111-AM) = "07"			Service Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	2 = Service Billing	M	<i>Imp Guide:</i> For Transaction Code of "S1" or "S3" in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "2" (Service Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	07 = CPT4 09 = HCPCS	M	<i>Imp Guide:</i> If the Product/Service ID Qualifier (436-E1) = "06" (DUR/PPS), the Product/Service ID (407-D7) is zero. (Zero means "0".) <i>Payer Requirement:</i> S1 transactions are limited to qualifiers 07 and 09.
407-D7	PRODUCT/SERVICE ID		M	<i>Imp Guide:</i> If the Product/Service ID Qualifier (436-E1) = "06" (DUR/PPS), the Product/Service ID (407-D7) is zero. (Zero means "0".) Populate the DUR/PPS segment as appropriate. If the Product/Service ID Qualifier (436-E1) = "07" (CPT-4), the Product Service ID (407-D7) is the actual CPT-4 value. If the Product/Service ID Qualifier (436-E1) = "09" (HCPCS), the Product Service ID (407-D7) is the actual HCPCS value. If the Product/Service ID Qualifier (436-E1) = "99" (Other), the Product Service ID (407-D7) is the business partner agreed value. <i>Payer Requirement:</i> Mandatory; see values supported.
442-E7	QUANTITY DISPENSED		RW	<i>Imp Guide:</i> Required if value is greater than zero (0). <i>Payer Requirement:</i> Quantity Dispensed for S1 claim request = 1.

Claim Segment Segment Identification (111-AM) = "07"				Service Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
403-D3	FILL NUMBER		RW	<i>Imp Guide:</i> Required if necessary for plan benefit administration. <i>Payer Requirement:</i> Required.
414-DE	DATE PRESCRIPTION WRITTEN		RW	<i>Imp Guide:</i> Required if necessary for plan benefit administration. <i>Payer Requirement:</i> The date the billed service was ordered. It may be the same date submitted in the DATE of SERVICE (401-D1) field.
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. <i>Payer Requirement:</i> Required.

Pricing Segment Questions	Check	Service Billing If Situational, Payer Situation
This Segment is always sent	X	

Pricing Segment Segment Identification (111-AM) = "11"				Service Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
477-BE	PROFESSIONAL SERVICE FEE SUBMITTED		R	
430-DU	GROSS AMOUNT DUE		R	

Pharmacy Provider Segment Questions	Check	Service Billing If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Payer Requirement: Required for service billing.

Pharmacy Provider Segment Segment Identification (111-AM) = "02"				Service Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
465-EY	PROVIDER ID QUALIFIER		RW	<i>Imp Guide:</i> Required if Provider ID (444-E9) is used. <i>Payer Requirement:</i> Required.
449-E9	PROVIDER ID		RW	<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs. Required if necessary to determine if provider is credentialed to perform this service. Required if needed for reconciliation of encounter-reported data or encounter reporting. <i>Payer Requirement:</i> Required to identify the clinician performing the service.

Prescriber Segment Questions	Check	Service Billing If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>Payer Requirement: Required when necessary to communicate information about a referring prescriber.</i>

Prescriber Segment Segment Identification (111-AM) = "03"				Service Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
446-EZ	PRESCRIBER ID QUALIFIER		RW	<i>Imp Guide: Required if Prescriber ID (411-DB) is used. Payer Requirement: Same as Imp Guide.</i>
411-DB	PRESCRIBER ID		RW	<i>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 when a prescriber has ordered/referred this specific professional service(s) to be performed by the pharmacist.</i>

DUR/PPS Segment Questions	Check	Service Billing If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>Payer Requirement: Use of DUR/PPS Segment in an S1 request is limited to the communication of additional professional service information that supplements the service billed in the Product Service ID (407-D7) field, using Product Service ID Qualifier (436-E1) values 08, 09.</i>

DUR/PPS Segment Segment Identification (111-AM) = "08"				Service Billing/Service Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	<i>Imp Guide: Required if DUR/PPS Segment is used. Payer Requirement: Same as Imp Guide.</i>
439-E4	REASON FOR SERVICE CODE		RW	<i>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. Payer Requirement: Same as Imp Guide.</i>
440-E5	PROFESSIONAL SERVICE CODE		RW	<i>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. Payer Requirement: Same as Imp Guide.</i>

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	DUR/PPS Segment Segment Identification (111-AM) = "08"			Service Billing/Service Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
441-E6	RESULT OF SERVICE CODE		RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.</p> <p>Required if this field affects payment for or documentation of professional pharmacy service.</p> <p><i>Payer Requirement: Same as Imp Guide.</i></p>
474-8E	DUR/PPS LEVEL OF EFFORT		RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.</p> <p>Required if this field affects payment for or documentation of professional pharmacy service.</p> <p><i>Payer Requirement: Same as Imp Guide.</i></p>

Clinical Segment Questions	Check	Service Billing If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>Payer Requirement: Required when necessary to specify clinical measurements and/or diagnosis information associated with the Service Billing transaction.</i>

	Clinical Segment Segment Identification (111-AM) = "13"			Service Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	<p><i>Imp Guide:</i> Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.</p> <p><i>Payer Requirement: Same as Imp Guide.</i></p>
492-WE	DIAGNOSIS CODE QUALIFIER	02 = ICD10	RW	<p><i>Imp Guide:</i> Required if Diagnosis Code (424-DO) is used.</p> <p><i>Payer Requirement: Same as Imp Guide.</i></p>
424-DO	DIAGNOSIS CODE		RW	<p><i>Imp Guide:</i> The value for this field is obtained from the prescriber or authorized representative.</p> <p>Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.</p> <p>Required if this field affects payment for professional pharmacy service.</p> <p>Required if this information can be used in place of prior authorization.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement: Same as Imp Guide.</i></p>

** End of Service Billing Request (S1) Payer Sheet Template**

9.1.1.2 SERVICE BILLING ACCEPTED/PAID (OR DUPLICATE OF PAID) RESPONSE

GENERAL INFORMATION

Payer Name: Services Unlimited	Date: 01/01/2024
Plan Name/Group Name: Health Service of America	BIN: 11111 PCN: SERV

SERVICE BILLING ACCEPTED/PAID (OR DUPLICATE OF PAID) RESPONSE

Response Transaction Header Segment Questions	Check	Service Billing – Accepted/Paid (Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Service Billing – Accepted/Paid (Duplicate of Paid) Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	S1	M	Service 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 Insurance Header Segment Questions	Check	Service Billing – Accepted/Paid (Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Service Billing/Service Rebill – Accepted/Paid (Duplicate of Paid) Payer Situation
301-C1	GROUP ID		RW	<p><i>Imp Guide:</i> Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available.</p> <p>Required to identify the actual group that was used when multiple group coverages exist.</p> <p><i>Payer Requirement: Will be returned.</i></p>
545-2F	NETWORK REIMBURSEMENT ID		RW	<p><i>Imp Guide:</i> Required if needed to identify the network for the covered member.</p> <p>Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available.</p> <p>Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist.</p> <p><i>Payer Requirement: Will be returned.</i></p>

Response Status Segment Questions	Check	Service Billing – Accepted/Paid (Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Response Status Segment Segment Identification (111-AM) = "21"		Service Billing – Accepted/Paid (Duplicate of Paid)

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NCPDP Payer Sheet Template

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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. <i>Payer Requirement:</i> Will contain the traceback number of the claim.
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. <i>Payer Requirement:</i> Will be returned.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.

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

Response Claim Segment Segment Identification (111-AM) = "22"				Service Billing – Accepted/Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	2 = Service Billing	M	<i>Imp Guide:</i> For Transaction Code of "S1" or "S3", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "2" (Service Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

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

Response Pricing Segment Segment Identification (111-AM) = "23"				Service Billing – Accepted/Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
505-F5	PATIENT PAY AMOUNT		R	
557-AV	TAX EXEMPT INDICATOR		RW	<i>Imp Guide:</i> Required if the sender (health plan) and/or patient is tax exempt and exemption applies to this billing. <i>Payer Requirement:</i> Same as Imp Guide.

	Response Pricing Segment Segment Identification (111-AM) = "23"			Service Billing – Accepted/Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
558-AW	FLAT SALES TAX AMOUNT PAID		RW	<i>Imp Guide:</i> Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (0) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement. <i>Payer Requirement: Same as Imp Guide.</i>
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		RW	<i>Imp Guide:</i> 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 (0). Required if Percentage Sales Tax Rate Paid (560-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used. <i>Payer Requirement: Same as Imp Guide.</i>
560-AY	PERCENTAGE SALES TAX RATE PAID		RW	<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (0). <i>Payer Requirement: Same as Imp Guide.</i>
562-J1	PROFESSIONAL SERVICE FEE PAID		R	
509-F9	TOTAL AMOUNT PAID		R	
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes deductible <i>Payer Requirement: Same as Imp Guide.</i>
518-FI	AMOUNT OF COPAY		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes copay as patient financial responsibility. <i>Payer Requirement: Same as Imp Guide.</i>
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes amount exceeding periodic benefit maximum. <i>Payer Requirement: Same as Imp Guide.</i>
572-4U	AMOUNT OF COINSURANCE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes coinsurance as patient financial responsibility. <i>Payer Requirement: Same as Imp Guide.</i>
575-EQ	PATIENT SALES TAX AMOUNT		RW	<i>Imp Guide:</i> Used when necessary to identify the Patient's portion of the Sales Tax. <i>Payer Requirement: Same as Imp Guide.</i>
574-2Y	PLAN SALES TAX AMOUNT		RW	<i>Imp Guide:</i> Used when necessary to identify the Plan's portion of the Sales Tax. Provided for informational purposes only. <i>Payer Requirement: Same as Imp Guide.</i>

Response DUR/PPS Segment Questions	Check	Service Billing – Accepted/Paid If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>Payer Requirement: This segment may be returned to communicate additional professional service opportunities.</i>

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Service Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used. <i>Payer Requirement:</i> Same as Imp Guide.
439-E4	REASON FOR SERVICE CODE		RW	<i>Imp Guide:</i> Required if professional service opportunity reason is detected by the receiver that is different from the professional service submitted. <i>Payer Requirement:</i> Same as Imp Guide.
533-FX	OTHER PRESCRIBER INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the service. <i>Payer Requirement:</i> Same as Imp Guide.
544-FY	DUR FREE TEXT MESSAGE		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the service. <i>Payer Requirement:</i> Same as Imp Guide.
570-NS	DUR ADDITIONAL TEXT		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the service. <i>Payer Requirement:</i> Same as Imp Guide.

9.1.1.3 SERVICE BILLING ACCEPTED/REJECTED RESPONSE

SERVICE BILLING ACCEPTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Service Billing – Accepted/Rejected If Situational, Payer Situation
This Segment is always sent	X	

	Response Transaction Header Segment			Service Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	S1	M	Service 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 Segment Questions	Check	Service Billing – Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>Payer Requirement:</i> Will be returned when applicable on rejected claims.

	Response Message Segment Segment Identification (111-AM) = "20"			Service Billing – Accepted/Rejected
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. <i>Payer Requirement:</i> Will be returned when text information needs to be sent.

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Response Patient Segment Questions	Check	Service Billing – Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Payer Requirement: Will be returned if patient can be found.</i>

Response Patient Segment Segment Identification (111-AM) = "29"				Service Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME		RW	<i>Imp Guide:</i> Required if known. <i>Payer Requirement: Will be returned if patient can be found.</i>
311-CB	PATIENT LAST NAME		RW	<i>Imp Guide:</i> Required if known. <i>Payer Requirement: Will be returned if patient can be found.</i>
304-C4	DATE OF BIRTH		RW	<i>Imp Guide:</i> Required if known. <i>Payer Requirement: Will be returned if patient can be found.</i>

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

Response Status Segment Segment Identification (111-AM) = "21"				Service Billing – Accepted/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	<i>NCPDP Reject Codes</i>	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement: Same as Imp Guide.</i>
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.
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. <i>Payer Requirement: Will be returned.</i>
549-7F	HELP DESK PHONE NUMBER QUALIFIER	<i>03 = Processor/PBM</i>	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement: Will be returned.</i>
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement: Will be returned.</i>

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

Response Claim Segment Segment Identification (111-AM) = "22"				Service Billing – Accepted/Rejected
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Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	2 = Service Billing	M	<i>Imp Guide:</i> For Transaction Code of "S1" or "S3", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "2" (Service Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

9.1.1.4 SERVICE BILLING REJECTED/REJECTED RESPONSE

SERVICE BILLING REJECTED/REJECTED RESPONSE

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	S1	M	Service 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 Segment Questions	Check	Service Billing – Rejected/Rejected <i>If Situational, Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Payer Requirement: Will be returned on rejected claims when the error is at transmission-level.</i>

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail. <i>Payer Requirement: Will be returned on rejected claims when the error is in Transaction Header fields.</i>

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	<i>NCPDP Reject Codes</i>	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement: Same as Imp Guide.</i>

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	Response Status Segment Segment Identification (111-AM) = "21"			Service Billing – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
130-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. Payer Requirement: Will be returned.
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 Imp Guide.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	Imp Guide: Required if Help Desk Phone Number (550-8F) is used. Payer Requirement: Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	Imp Guide: Required if needed to provide a support telephone number to the receiver. Payer Requirement: Will be returned.

** End of Service Billing Response (S1) Payer Sheet Template**

9.1.2 SERVICE REVERSALS

Same plan - continuation of the example of a payer sheet with information about service reversals. The payer sheet shows an approved and a rejected response.

- [Service Reversal Request](#)
- [Service Reversal Accepted/Approved](#)
- [Service Reversal Accepted/Rejected](#)
- [Service Reversal Rejected/Rejected](#)

9.1.2.1 SERVICE REVERSAL REQUEST

** Start of Request Service Reversal (S2) Payer Sheet Template**

GENERAL INFORMATION

Payer Name: Services Unlimited	Date: 07/01/2024	
Plan Name/Group Name: Health Plan of America	BIN: 111111	PCN: Blank fill

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

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

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SERVICE REVERSAL TRANSACTION

Transaction Header Segment Questions	Check	Service Reversal If Situational, Payer Situation
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued		
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	X	

Transaction Header Segment				Service Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN NUMBER	111111	M	BIN for Health Plan of America
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	S2	M	Service Reversal
104-A4	PROCESSOR CONTROL NUMBER	Blank fill	M	Blank fill
109-A9	TRANSACTION COUNT	01 = One occurrence	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M	
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill

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

Insurance Segment Segment Identification (111-AM) = "04"				Service Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	Member's ID as shown on card.
301-C1	GROUP ID		RW	Imp Guide: Required if needed to match the reversal to the original billing transaction. Payer Requirement: Required.

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

Claim Segment Segment Identification (111-AM) = "07"				Service Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	2 = Service Billing	M	Imp Guide: For Transaction Code of "S2", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "2" (Service Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	07 = CPT4 09 = HCPCS	M	
407-D7	PRODUCT/SERVICE ID		M	
403-D3	FILL NUMBER		RW	Imp Guide: Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (402-D2) occur on the same day. Payer Requirement: Same as Imp Guide.

** End of Service Reversal Request (S2) Payer Sheet Template**

9.1.2.2 SERVICE REVERSAL ACCEPTED/APPROVED RESPONSE

** Start of Service Reversal Response (S2) Payer Sheet Template**

GENERAL INFORMATION

Payer Name: Services Unlimited	Date: 07/01/2024
Plan Name/Group Name: Health Plan of America	BIN: 111111 PCN: Blank fill

SERVICE REVERSAL ACCEPTED/APPROVED RESPONSE

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	S2	M	Service 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 Status Segment Questions	Check	Service Reversal – Accepted/Approved <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	A = 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.
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. <i>Payer Requirement:</i> Will be returned.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.

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

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	Response Claim Segment Segment Identification (111-AM) = "22"			Service Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	2 = Service Billing	M	<i>Imp Guide:</i> For Transaction Code of "S2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "2" (Service Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

9.1.2.3 SERVICE REVERSAL ACCEPTED/REJECTED RESPONSE

SERVICE REVERSAL ACCEPTED/REJECTED RESPONSE

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

	Transaction Header Segment			Service Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	S2	M	Service 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 01 = 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	Service Reversal - Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>Payer Requirement: Will be returned when applicable on rejected claims .</i>

	Response Message Segment Segment Identification (111-AM) = "20"			Service Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail. <i>Payer Requirement: Will be returned when text information needs to be sent.</i>

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

	Response Status Segment Segment Identification (111-AM) = "21"			Service Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Reject Codes	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement: Same as Imp Guide.</i>

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	Response Status Segment Segment Identification (111-AM) = "21"			Service Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.
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. <i>Payer Requirement:</i> Will be returned.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.

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

	Response Claim Segment Segment Identification (111-AM) = "22"			Service Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	2 = Service Billing	M	<i>Imp Guide:</i> For Transaction Code of "S2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "2" (Service Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

9.1.2.4 SERVICE REVERSAL REJECTED/REJECTED RESPONSE

SERVICE REVERSAL REJECTED/REJECTED RESPONSE

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

	Transaction Header Segment			Service Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	S2	M	Service 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	Service Reversal – Rejected/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>Payer Requirement:</i> Will be returned on rejected claims when the error is at transmission-level.

	Response Message Segment Segment Identification (111-AM) = "20"			Service Reversal – Rejected/Rejected
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NCPDP Payer Sheet Template

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

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

Response Status Segment Segment Identification (111-AM) = "21"				Service Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Reject Codes	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement:</i> Same as Imp Guide.
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. <i>Payer Requirement:</i> Will be returned.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.

**** End of Service Reversal Response (S2) Payer Sheet Template****

10. EXAMPLE 3 – ABC, INC. PAYER SHEET – TWO PLANS

Two Plans - Workers' Compensation Claim Billing and Claim Reversal and Non-Workers' Compensation Claim Billing and Claim Reversal
 In this example, a payer has two plans. One plan accepts workers' compensation claims billings (City Wide Health Plan). The payer sheet shows how this payer would expect to receive a standard request and how the payer would respond. One plan accepts non-workers' compensation claims billings (General Health Plan). Neither plan accepts claims rebills, so references on the prepared payer template to Claim Rebills have been removed. Neither plan participates in Medicare Part D processing. According to the rules in section "[Plan Differentiation](#)", two payer sheets must be filled out. Each payer sheet shows a paid and a rejected response.

- [Workers' Compensation Claim Billing Request](#)
- [Workers' Compensation Claim Billing Accepted/Paid Response](#)
- [Workers' Compensation Claim Billing Accepted/Rejected Response](#)
- [Workers' Compensation Claim Billing Rejected/Rejected Response](#)
- [Workers' Compensation Claim Reversal Request](#)
- [Workers' Compensation Claim Reversal Accepted/Approved Response](#)
- [Workers' Compensation Claim Reversal Accepted/Rejected Response](#)
- [Workers' Compensation Claim Reversal Rejected/Rejected Response](#)
- [Non-Workers' Compensation Claim Billing Request](#)
- [Non-Workers' Compensation Claim Billing Accepted/Paid Response](#)
- [Non-Workers' Compensation Claim Billing Accepted/Rejected Response](#)
- [Non-Workers' Compensation Claim Billing Rejected/Rejected Response](#)
- [Non-Workers' Compensation Claim Reversal Request](#)
- [Non-Workers' Compensation Claim Reversal Accepted/Approved Response](#)
- [Non-Workers' Compensation Claim Reversal Accepted/Rejected Response](#)
- [Non-Workers' Compensation Claim Reversal Rejected/Rejected Response](#)

10.1.1 WORKERS' COMPENSATION CLAIM BILLING 10.1.1.1 WORKERS' COMPENSATION CLAIM BILLING REQUEST

** Start of Request Claim Billing Payer Sheet Template**

GENERAL INFORMATION

Payer Name: ABC, Inc. Workers' Comp		Date: 01/01/2010
Plan Name/Group Name: City Wide Health Plan for Workers' Comp		BIN: 772211 PCN: Blank fill
Processor:		
Effective as of: 07/01/2010		NCPDP Telecommunication Standard Version/Release #: D.0
NCPDP Data Dictionary Version Date: 07/2007		NCPDP External Code List Version Date: 01/2008
Contact/Information Source: General website www.abcinc.com Provider Manuals available at www.abcinc.com/manuals		
Certification Testing Window: Monday – Wednesday, 7 am PT – 7 pm PT test against automated system		
Certification Contact Information: 222-333-4444 x 120 Certification Help Desk		
Provider Relations Help Desk Info: 888-444-5555		
Other versions supported: NCPDP Telecommunication version 5.1 until further notice		

OTHER TRANSACTIONS SUPPORTED

Transaction Code	Transaction Name
B2	Claim Reversal

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

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

CLAIM BILLING TRANSACTION

Transaction Header Segment Questions	Check	Worker's Comp Claim Billing If Situational, Payer Situation
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued		
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	X	

Field #	Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Worker's Comp Claim Billing Payer Situation
101-A1	BIN NUMBER	772211	M	BIN for City Wide Health Plan for Workers' Comp
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1	M	Claim Billing
104-A4	PROCESSOR CONTROL NUMBER	Blank fill	M	Blank fill
109-A9	TRANSACTION COUNT	01 = One occurrence	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M	
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill

Insurance Segment Questions	Check	Worker's Comp Claim Billing If Situational, Payer Situation
This Segment is always sent	X	

Field #	Insurance Segment Segment Identification (111-AM) = "04"	Value	Payer Usage	Worker's Comp Claim Billing Payer Situation
302-C2	CARDHOLDER ID		M	Personal identification number provided by the injured worker

Patient Segment Questions	Check	Worker's Comp Claim Billing If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Field	Patient Segment Segment Identification (111-AM) = "01"	Value	Payer Usage	Worker's Comp Claim Billing Payer Situation
304-C4	DATE OF BIRTH		R	
305-C5	PATIENT GENDER CODE		R	
310-CA	PATIENT FIRST NAME		RW	Imp Guide: Required when the patient has a first name. Payer Requirement: Required for Workers' Compensation.
311-CB	PATIENT LAST NAME		R	

Patient Segment Segment Identification (111-AM) = "01"			Worker's Comp Claim Billing	
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
333-CZ	EMPLOYER ID		RW	<p>Imp Guide: Required if "required by law" as defined in the HIPAA final Privacy regulations section 164.501 definitions (45 CFR Parts 160 and 164 Standards for Privacy of Individually Identifiable Health Information; Final Rule - Thursday, December 28, 2000, page 82803 and following, and Wednesday, August 14, 2002, page 53267 and following.)</p> <p>Required if needed for Workers' Compensation billing.</p> <p>Payer Requirement: Required for Workers' Compensation.</p>

Claim Segment Questions	Check	Worker's Comp Claim Billing If Situational, Payer Situation
This Segment is always sent	X	
This payer supports partial fills		
This payer does not support partial fills	X	

Claim Segment Segment Identification (111-AM) = "07"			Worker's Comp Claim Billing	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	<p>Imp Guide: For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).</p>
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	<p>01 = Universal Product Code (UPC)</p> <p>03 = National Drug Code (NDC)</p>	M	
407-D7	PRODUCT/SERVICE ID		M	
442-E7	QUANTITY DISPENSED		R	
403-D3	FILL NUMBER		R	
405-D5	DAYS SUPPLY		R	
406-D6	COMPOUND CODE	<p>01 = Not a Compound</p> <p>02 = Compound</p> <p>See Compound Segment for support of multi-ingredient compounds</p>	R	
408-D8	DISPENSE AS WRITTEN (DAW/PRODUCT SELECTION CODE)	All values supported.	R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	<p>Imp Guide: Required if Submission Clarification Code (420-DK) is used.</p> <p>Payer Requirement: Same as Imp Guide.</p>

Claim Segment Segment Identification (111-AM) = "07"				Worker's Comp Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
420-DK	SUBMISSION CLARIFICATION CODE	All values supported.	RW	<p>Imp Guide: Required if clarification is needed and value submitted is greater than zero (0).</p> <p>If the Date of Service (401-D1) contains the subsequent payer coverage date, the Submission Clarification Code (420-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.</p> <p>Payer Requirement: Required when claim explanation is needed for overrides.</p>
308-C8	OTHER COVERAGE CODE	All values supported.	RW	<p>Imp Guide: Required if needed by receiver, to communicate a summation of other coverage information collected from other payers.</p> <p>Required for Coordination of Benefits.</p> <p>Payer Requirement: Only used in COB claims.</p>
995-E2	ROUTE OF ADMINISTRATION		RW	<p>Imp Guide: Required if specified in trading partner agreement.</p> <p>Payer Requirement: Required when Compound Code (406-D6) = 2 (compound).</p>

Pricing Segment Questions	Check	Worker's Comp Claim Billing If Situational, Payer Situation
This Segment is always sent	X	

Pricing Segment Segment Identification (111-AM) = "11"				Worker's Comp Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	INGREDIENT COST SUBMITTED		R	
430-DU	GROSS AMOUNT DUE		R	
426-DQ	USUAL AND CUSTOMARY CHARGE		RW	<p>Imp Guide: Required if needed per trading partner agreement.</p> <p>Payer Requirement: Required for Workers' Compensation.</p>

Prescriber Segment Questions	Check	Worker's Comp Claim Billing If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Prescriber Segment Segment Identification (111-AM) = "03"				Worker's Comp Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	All values supported.	RW	<p>Imp Guide: Required if Prescriber ID (411-DB) is used.</p> <p>Payer Requirement: Required for Workers' Compensation.</p>

Prescriber Segment Segment Identification (111-AM) = "03"			Worker's Comp Claim Billing	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
411-DB	PRESCRIBER ID		RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage or patient financial responsibility.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p>Payer Requirement: Required for Workers' Compensation.</p>
498-PM	PRESCRIBER PHONE NUMBER		RW	<p><i>Imp Guide:</i> Required if needed for Workers' Compensation.</p> <p>Required if needed to assist in identifying the prescriber.</p> <p>Required if needed for Prior Authorization process.</p> <p>Payer Requirement: Required for Workers' Compensation.</p>

Workers' Compensation Segment Questions	Check	Worker's Comp Claim Billing If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Workers' Compensation Segment Segment Identification (111-AM) = "06"			Worker's Comp Claim Billing	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
434-DY	DATE OF INJURY		M	
315-CF	EMPLOYER NAME		RW	<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p>Payer Requirement: Required.</p>
316-CG	EMPLOYER STREET ADDRESS		RW	<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p>Payer Requirement: Required.</p>
317-CH	EMPLOYER CITY ADDRESS		RW	<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p>Payer Requirement: Required.</p>
318-CI	EMPLOYER STATE/PROVINCE ADDRESS		RW	<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p>Payer Requirement: Required.</p>
319-CJ	EMPLOYER ZIP/POSTAL ZONE		RW	<p><i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition.</p> <p>Payer Requirement: Required.</p>

Workers' Compensation Segment Segment Identification (111-AM) = "06"			Worker's Comp Claim Billing	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
320-CK	EMPLOYER PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition. <i>Payer Requirement:</i> Required.
327-CR	CARRIER ID		RW	<i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition. <i>Payer Requirement:</i> Required for carrier number from workers' comp form when known, otherwise do not send.
435-DZ	CLAIM/REFERENCE ID		RW	<i>Imp Guide:</i> Required if needed to process a claim/encounter for a work-related injury or condition. <i>Payer Requirement:</i> Required for claim number from workers' comp form when known, otherwise do not send.
117-TR	BILLING ENTITY TYPE INDICATOR	All values supported.	R	
118-TS	PAY TO QUALIFIER	All values supported.	RW	<i>Imp Guide:</i> Required if Pay To ID (119-TT) is used. <i>Payer Requirement:</i> Same as Imp Guide.
119-TT	PAY TO ID		RW	<i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party. <i>Payer Requirement:</i> Same as Imp Guide.
120-TU	PAY TO NAME		RW	<i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party. <i>Payer Requirement:</i> Same as Imp Guide.
121-TV	PAY TO STREET ADDRESS		RW	<i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party. <i>Payer Requirement:</i> Same as Imp Guide.
122-TW	PAY TO CITY ADDRESS		RW	<i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party. <i>Payer Requirement:</i> Same as Imp Guide.
123-TX	PAY TO STATE/PROVINCE ADDRESS		RW	<i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party. <i>Payer Requirement:</i> Same as Imp Guide.
124-TY	PAY TO ZIP/POSTAL ZONE		RW	<i>Imp Guide:</i> Required if transaction is submitted by a provider or agent but paid to another party. <i>Payer Requirement:</i> Same as Imp Guide.

Coordination of Benefits/Other Payments Segment Questions	Check	Worker's Comp Claim Billing If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc. claims.
Scenario 1 - Other Payer Amount Paid Repetitions Only		
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only	X	Required when Other Coverage Code = 8 (Claim is billing for patient financial responsibility)
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount and Benefit Stage Repetitions Present (Government Programs)		

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"			Worker's Comp Claim Billing Scenario 2 - Other Payer- Patient Responsibility Amount Repetitions Only Payer Situation
Field #	NCPDP Field Name	Value	Payer Usage	
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE	All values supported.	M	
339-6C	OTHER PAYER ID QUALIFIER	03 = BIN	RW	Imp Guide: Required if Other Payer ID (340-7C) is used. Payer Requirement: Required when claim has been paid or rejected by previous payer(s).
340-7C	OTHER PAYER ID		RW	Imp Guide: Required if identification of the Other Payer is necessary for claim/encounter adjudication. Payer Requirement: Required when claim has been paid or rejected by previous payer(s).
443-E8	OTHER PAYER DATE		RW	Imp Guide: Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. Payer Requirement: Required when claim has been paid or rejected by previous payer(s).
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	Imp Guide: Required if Other Payer Reject Code (472-6E) is used. Payer Requirement: Required when claim has been rejected by previous payer(s).
472-6E	OTHER PAYER REJECT CODE		RW	Imp Guide: Required when the other payer has denied the payment for the billing. Payer Requirement: Required when claim has been rejected by previous payer(s).
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	Imp Guide: Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. Payer Requirement: Same as Imp Guide.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	All values supported.	RW	Imp Guide: Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. Payer Requirement: Same as Imp Guide.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"			Worker's Comp Claim Billing	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	<p><i>Imp Guide:</i> Required if necessary for patient financial responsibility only billing.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p>Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted.</p> <p><i>Payer Requirement:</i> Required.</p>

Compound Segment Questions	Check	Worker's Comp Claim Billing 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"			Worker's Comp Claim Billing	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	All values supported.	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	All values supported.	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum of 25 ingredients.	M	<i>Payer Requirement:</i> Maximum of 10 ingredients.
488-RE	COMPOUND PRODUCT ID QUALIFIER	01 = Universal Product Code (UPC) 03 = National Drug Code(NDC)	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		RW	<p><i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed.</p> <p><i>Payer Requirement:</i> Required for each ingredient.</p>

**** End of Request Claim Billing (B1) Payer Sheet Template****

10.1.1.2 WORKERS' COMPENSATION CLAIM BILLING ACCEPTED/PAID (OR DUPLICATE OF PAID) RESPONSE

**** Start of Response Claim Billing (B1) Payer Sheet Template****

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

Response Transaction Header Segment Questions	Check	Worker's Comp Claim Billing – Paid (Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Response Transaction Header Segment			Worker's Comp Claim Billing – Paid (Duplicate of Paid)	
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	

NCPDP Payer Sheet Template

	Response Transaction Header Segment			Worker's Comp Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Worker's Comp Claim Billing – Paid (Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging.

	Response Message Segment Segment Identification (111-AM) = "20"			Worker's Comp Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	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 Patient Segment Questions	Check	Worker's Comp Claim Billing – Paid (Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	XXX

	Response Patient Segment Segment Identification (111-AM) = "29"			Worker's Comp Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME		RW	Imp Guide: Payer Requirement: Will be sent every time.
311-CB	PATIENT LAST NAME		RW	Imp Guide: Payer Requirement: Will be sent every time.
304-C4	DATE OF BIRTH		RW	Imp Guide: Payer Requirement: Will be sent every time.

Response Status Segment Questions	Check	Worker's Comp Claim Billing – Paid (Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Worker's Comp Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
503-F3	AUTHORIZATION NUMBER		RW	Imp Guide: Required if needed to identify the transaction. Payer Requirement: Will contain the trace back number of the claim.

Response Status Segment Segment Identification (111-AM) = "21"				Worker's Comp Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Maximum count of 2 will be returned.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	01 = Used for first line of free form text with no pre-defined structure. 02 = Used for second line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Only qualifier values cited will be returned.
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.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> Same as Imp Guide.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.

Response Claim Segment Questions	Check	Worker's Comp Claim Billing – Paid (Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

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

Response Pricing Segment Questions	Check	Worker's Comp Claim Billing – Paid (Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Response Pricing Segment Segment Identification (111-AM) = "23"				Worker's Comp Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	

	Response Pricing Segment Segment Identification (111-AM) = "23"			Worker's Comp Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
507-F7	DISPENSING FEE PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement. <i>Payer Requirement: Same as Imp Guide.</i>
557-AV	TAX EXEMPT INDICATOR		RW	<i>Imp Guide:</i> Required if the sender (health plan) and/or patient is tax exempt and exemption applies to this billing. <i>Payer Requirement: Same as Imp Guide.</i>
558-AW	FLAT SALES TAX AMOUNT PAID		RW	<i>Imp Guide:</i> Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (0) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement. <i>Payer Requirement: Same as Imp Guide.</i>
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		RW	<i>Imp Guide:</i> 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 (0). Required if Percentage Sales Tax Rate Paid (560-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used. <i>Payer Requirement: Same as Imp Guide.</i>
560-AY	PERCENTAGE SALES TAX RATE PAID		RW	<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (0). <i>Payer Requirement: Same as Imp Guide.</i>
561-AZ	PERCENTAGE SALES TAX BASIS PAID		RW	<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (0). <i>Payer Requirement: Same as Imp Guide.</i>
521-FL	INCENTIVE AMOUNT PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement. Required if Incentive Amount Submitted (438-E3) is greater than zero (0). <i>Payer Requirement: Same as Imp Guide.</i>
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used. <i>Payer Requirement: Will be returned when submission includes Other Amount Claimed Submitted.</i>
564-J3	OTHER AMOUNT PAID QUALIFIER	All values supported	RW	<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used. <i>Payer Requirement: Will be returned when submission includes Other Amount Claimed Submitted.</i>

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	Response Pricing Segment Segment Identification (111-AM) = "23"			Worker's Comp Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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 (480-H9) is greater than zero (0).</p> <p><i>Payer Requirement:</i> Will be returned when submission includes Other Amount Claimed Submitted.</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 (0) and Coordination of Benefits/Other Payments Segment is supported.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
509-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 & 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 (506-F6) is greater than zero (0).</p> <p>Required if Basis of Cost Determination (432-DN) is submitted on billing.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes deductible</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
572-4U	AMOUNT OF COINSURANCE			<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes coinsurance as patient financial responsibility.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
575-EQ	PATIENT SALES TAX AMOUNT		RW	<p><i>Imp Guide:</i> Used when necessary to identify the Patient's portion of the Sales Tax.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
574-2Y	PLAN SALES TAX AMOUNT		RW	<p><i>Imp Guide:</i> Used when necessary to identify the Plan's portion of the Sales Tax. Provided for informational purposes only.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>

Response Coordination of Benefits/Other Payers Segment Questions	Check	Worker's Comp Claim Billing – Paid (Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Will be returned when other payers involved.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Worker's Comp Claim Billing – Paid (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	All values supported.	M	

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Worker's Comp Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
339-6C	OTHER PAYER ID QUALIFIER	03 = BIN	RW	Imp Guide: Required if Other Payer ID (340-7C) is used. Payer Requirement: Same as Imp Guide.
340-7C	OTHER PAYER ID		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
356-NU	OTHER PAYER CARDHOLDER ID		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
992-MJ	OTHER PAYER GROUP ID		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
142-UV	OTHER PAYER PERSON CODE		RW	Imp Guide: Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer. Payer Requirement: Same as Imp Guide.
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	Imp Guide: Required if needed to provide a support telephone number of the other payer to the receiver. Payer Requirement: Same as Imp Guide.
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	Imp Guide: Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer. Payer Requirement: Same as Imp Guide.

10.1.1.3 WORKERS' COMPENSATION CLAIM BILLING ACCEPTED/REJECTED RESPONSE

CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

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

	Response Transaction Header Segment			Workers' Comp Claim Billing – Accepted/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	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	

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NCPDP Payer Sheet Template

Response Transaction Header Segment				Workers' Comp Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Workers' Comp Claim Billing – 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.

Response Message Segment Segment Identification (111-AM) = "20"				Workers' Comp Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	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 Patient Segment Questions	Check	Workers' Comp Claim Billing – Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Will be returned if patient can be found.

Response Patient Segment Segment Identification (111-AM) = "29"				Workers' Comp Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME		RW	Imp Guide: Payer Requirement: Will be sent if patient can be found.
311-CB	PATIENT LAST NAME		RW	Imp Guide: Payer Requirement: Will be sent if patient can be found.
304-C4	DATE OF BIRTH		RW	Imp Guide: Payer Requirement: Will be sent if patient can be found.

Response Status Segment Questions	Check	Workers' Comp Claim Billing – Accepted/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Response Status Segment Segment Identification (111-AM) = "21"				Workers' Comp Claim Billing – Accepted/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	NCPDP Reject Codes	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: Only sent if reject is on a field that has multiple occurrences.

	Response Status Segment Segment Identification (111-AM) = "21"			Workers' Comp Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Maximum count of 2 will be returned.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	01 = Used for first line of free form text with no pre-defined structure. 02 = Used for second line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Only qualifier values cited will be returned.
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	02 = Intermediary	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.
987-MA	URL		RW	03 = National Drug Code (NDC)

Response Claim Segment Questions	Check	Workers' Comp Claim Billing – Accepted/Rejected If Situational, Payer Situation
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Workers' Comp Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	<i>Imp Guide:</i> For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
551-9F	PREFERRED PRODUCT COUNT	Maximum count of 6.	RW	<i>Imp Guide:</i> Required if Preferred Product ID (553-AR) is used. <i>Payer Requirement:</i> Preferred fields will be sent on a reject when there is a preferred product per the health plan's formulary.
552-AP	PREFERRED PRODUCT ID QUALIFIER	03 = National Drug Code (NDC)	RW	<i>Imp Guide:</i> Required if Preferred Product ID (553-AR) is used. <i>Payer Requirement:</i>
553-AR	PREFERRED PRODUCT ID		RW	<i>Imp Guide:</i> Required if a product preference exists that needs to be communicated to the receiver via an ID. <i>Payer Requirement:</i> Same as Imp Guide.
554-AS	PREFERRED PRODUCT INCENTIVE		RW	<i>Imp Guide:</i> Required if there is a known incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU). <i>Payer Requirement:</i> Same as Imp Guide.

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	Response Claim Segment Segment Identification (111-AM) = "22"			Workers' Comp Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
555-AT	PREFERRED PRODUCT COST SHARE INCENTIVE		RW	<i>Imp Guide:</i> Required if there is a known patient financial responsibility incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU). <i>Payer Requirement: Same as Imp Guide.</i>
556-AU	PREFERRED PRODUCT DESCRIPTION		RW	<i>Imp Guide:</i> 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). <i>Payer Requirement: Same as Imp Guide.</i>

Response DUR/PPS Segment Questions	Check	Workers' Comp Claim Billing – Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>This segment will be transmitted on a reject when a possible conflict is detected.</i>

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

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Workers' Comp Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
533-FX	OTHER PRESCRIBER INDICATOR	All values supported.	RW	Imp Guide: Required if needed to supply additional information for the utilization conflict. Payer Requirement: Same as Imp 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 Imp Guide.
570-NS	DUR ADDITIONAL TEXT		RW	Imp Guide: Required if Reason For Service Code (439-E4) is used. Payer Requirement: Same as Imp Guide.

Response Coordination of Benefits/Other Payers Segment Questions	Check	Workers' Comp Claim Billing – Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Will be sent if other payers known.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Workers' Comp Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE	All values supported.	M	
339-6C	OTHER PAYER ID QUALIFIER	03 = BIN	RW	Imp Guide: Required if Other Payer ID (340-7C) is used. Payer Requirement: Same as Imp Guide.
340-7C	OTHER PAYER ID		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
356-NU	OTHER PAYER CARDHOLDER ID		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
992-MJ	OTHER PAYER GROUP ID		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
142-UV	OTHER PAYER PERSON CODE		RW	Imp Guide: Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer. Payer Requirement: Same as Imp Guide.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Workers' Comp Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	Imp Guide: Required if needed to provide a support telephone number of the other payer to the receiver. Payer Requirement: Same as Imp Guide.
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	Imp Guide: Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer. Payer Requirement: Same as Imp Guide.

10.1.1.4 WORKERS' COMPENSATION CLAIM BILLING REJECTED/REJECTED RESPONSE

CLAIM BILLING REJECTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Workers' Comp Claim Billing – Rejected/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Field #	Response Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Workers' Comp Claim Billing – Rejected/Rejected 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 Segment Questions	Check	Workers' Comp Claim Billing – 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.

	Response Message Segment Segment Identification (111-AM) = "20"			Workers' Comp Claim Billing – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	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	Workers' Comp Claim Billing – Rejected/Rejected If Situational, Payer Situation
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Workers' Comp Claim Billing – 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	NCPDP Reject Codes	R	

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	Response Status Segment Segment Identification (111-AM) = "21"			Workers' Comp Claim Billing – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence. <i>Payer Requirement:</i> Same as Imp Guide.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Maximum count of 2 will be returned.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	01 = Used for first line of free form text with no pre-defined structure. 02 = Used for second line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Only qualifier values cited will be returned.
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.

**** End of Response Claim Billing (B1) Payer Sheet Template****

10.1.2 WORKERS' COMPENSATION CLAIM REVERSAL

This is a continuation of the example of a payer sheet for a plan with information about claims reversals for the workers' compensation plan. The payer sheet shows an approved and a rejected response.

10.1.2.1 WORKERS' COMPENSATION CLAIM REVERSAL REQUEST

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

GENERAL INFORMATION

Payer Name: ABC, Inc. Workers' Comp	Date: 01/01/2010	
Plan Name/Group Name City Wide Health Plan for Workers' Comp	BIN: 772211	PCN: Blank fill

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

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	90 Days

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CLAIM REVERSAL TRANSACTION

Transaction Header Segment Questions	Check	Workers' Comp Claim Reversal If Situational, Payer Situation
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued		
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	X	

Transaction Header Segment				Workers' Comp Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN NUMBER	772211	M	BIN for City Wide Health Plan for Workers' Comp
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	Claim Reversal
104-A4	PROCESSOR CONTROL NUMBER	Blank fill	M	Blank fill
109-A9	TRANSACTION COUNT	01 = One occurrence	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M	
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill

Insurance Segment Questions	Check	Workers' Comp Claim Reversal If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required to designate cardholder and specific group.

Insurance Segment Segment Identification (111-AM) = "04"				Workers' Comp Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	Personal identification number provided by the injured worker

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

Claim Segment Segment Identification (111-AM) = "07"				Workers' Comp 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).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	01 = Universal Product Code (UPC) 03 = National Drug Code (NDC)	M	
407-D7	PRODUCT/SERVICE ID		M	
403-D3	FILL NUMBER		RW	Imp Guide: Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (402-D2) occur on the same day. Payer Requirement: Same as Imp Guide.

Claim Segment Segment Identification (111-AM) = "07"			Workers' Comp Claim Reversal	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
308-C8	OTHER COVERAGE CODE		RW	Imp Guide: Required if needed by receiver to match the claim that is being reversed. Payer Requirement: Same as Imp Guide.

Pricing Segment Questions	Check	Workers' Comp Claim Reversal If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Submitted for Group IDs of 8771-8999.

Pricing Segment Segment Identification (111-AM) = "11"			Workers' Comp Claim Reversal	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	Imp Guide: Required if this field could result in contractually agreed upon payment. Payer Requirement: Submit based on contracted agreement.
430-DU	GROSS AMOUNT DUE		RW	Imp Guide: Required if this field could result in contractually agreed upon payment. Payer Requirement: If Incentive is sent, this field must be sent.

** End of Request Claim Reversal (B2) Payer Sheet Template**

10.1.2.2 WORKERS' COMPENSATION CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

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

GENERAL INFORMATION		
Payer Name: ABC, Inc. Workers' Comp	Date: 01/01/2010	
Plan Name/Group Name City Wide Health Plan for Workers' Comp	BIN: 772211	PCN: Blank fill

CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE		
Response Transaction Header Segment Questions	Check	Workers' Comp Claim Reversal – Accepted/Approved If Situational, Payer Situation
This Segment is always sent	X	

Response Transaction Header Segment			Workers' Comp Claim Reversal – Accepted/Approved	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	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 Status Segment Questions	Check	Workers' Comp Claim Reversal – Accepted/Approved If Situational, Payer Situation
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Workers' Comp Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	A = 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.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Maximum count of 2 will be returned.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	01 = Used for first line of free form text with no pre-defined structure. 02 = Used for second line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Only qualifier values cited will be returned.
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.

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

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

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

	Response Pricing Segment Segment Identification (111-AM) = "23"			Workers' Comp Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
521-FL	INCENTIVE AMOUNT PAID		RW	<i>Imp Guide:</i> Required if this field is reporting a contractually agreed upon payment. <i>Payer Requirement:</i> Will be returned.

	Response Pricing Segment Segment Identification (111-AM) = "23"			Workers' Comp Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
509-F9	TOTAL AMOUNT PAID		RW	Imp Guide: Required if any other payment fields sent by the sender. Payer Requirement: Will be returned.

10.1.2.3 WORKERS' COMPENSATION CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

CLAIM BILLING ACCEPTED/REJECTED RESPONSE

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

	Transaction Header Segment			Workers' Comp Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	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 Segment Questions	Check	Workers' Comp 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.

	Response Message Segment Segment Identification (111-AM) = "20"			Workers' Comp Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE			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	Workers' Comp Claim Reversal – Accepted/Rejected If Situational, Payer Situation
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Workers' Comp Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Reject Codes	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.

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	Response Status Segment Segment Identification (111-AM) = "21"			Workers' Comp Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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	01 = Used for first line of free form text with no pre-defined structure. 02 = 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.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Imp Guide: Required when additional text is needed for clarification or detail. Payer Requirement: Will be returned.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	Imp Guide: Required if Help Desk Phone Number (550-8F) is used. Payer Requirement: Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	Imp Guide: Required if needed to provide a support telephone number to the receiver. Payer Requirement: Will be returned.

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

	Response Claim Segment Segment Identification (111-AM) = "22"			Workers' Comp Claim Reversal – 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 "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	

10.1.2.4 WORKERS' COMPENSATION CLAIM REVERSAL REJECTED/REJECTED RESPONSE

CLAIM BILLING REJECTED/REJECTED RESPONSE

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

	Response Transaction Header Segment			Workers' Comp Claim Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	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	

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Response Message Segment Questions	Check	Workers' Comp 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.

	Response Message Segment Segment Identification (111-AM) = "20"			Workers' Comp Claim Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE			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	Workers' Comp Claim Reversal – Rejected/Rejected If Situational, Payer Situation
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Workers' Comp Claim Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Reject Codes	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	01 = Used for first line of free form text with no pre-defined structure. 02 = 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.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Imp Guide: Required when additional text is needed for clarification or detail. Payer Requirement: Will be returned.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	Imp Guide: Required if Help Desk Phone Number (550-8F) is used. Payer Requirement: Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	Imp Guide: Required if needed to provide a support telephone number to the receiver. Payer Requirement: Will be returned.

** End of Claim Reversal (B2) Response Payer Sheet Template**

10.1.3 NON-WORKERS' COMPENSATION CLAIM

General Health Plan information from the same payer as above, ABC, Inc.

10.1.3.1 NON-WORKERS' COMPENSATION CLAIM REQUEST

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**** Start of Request Claim Billing Payer Sheet Template****

GENERAL INFORMATION

Payer Name: ABC, Inc.		Date: 01/01/2010
Plan Name/Group Name: General Health Plan	BIN: 882211	PCN: Blank fill
Processor:		
Effective as of: 07/01/2010	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: 07/2007	NCPDP External Code List Version Date: 01/2008	
Contact/Information Source: General website www.abcinc.com Provider Manuals available at www.abcinc.com/manuals		
Certification Testing Window: Monday – Wednesday, 7 am PT – 7 pm PT test against automated system		
Certification Contact Information: 222-333-4444 x 120 Certification Help Desk		
Provider Relations Help Desk Info: 888-444-5555		
Other versions supported: NCPDP Telecommunication version 5.1 until further notice		

OTHER TRANSACTIONS SUPPORTED

Transaction Code	Transaction Name
B2	Claim Reversal

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

CLAIM BILLING TRANSACTION

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

Field #	Transaction Header Segment <i>NCPDP Field Name</i>	Value	Payer Usage	Claim Billing <i>Payer Situation</i>
101-A1	BIN NUMBER	882211	M	BIN for General Health Plan
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1	M	Claim Billing
104-A4	PROCESSOR CONTROL NUMBER	Blank fill	M	Blank fill
109-A9	TRANSACTION COUNT	01 = One occurrence	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M	
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill

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

	Insurance Segment Segment Identification (111-AM) = "04"			Claim Billing
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
302-C2	CARDHOLDER ID		M	Member's ID as shown on card.
303-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> This information is located at the end of the Cardholder ID on the Benefit Card.
306-C8	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> Required.

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

	Patient Segment Segment Identification (111-AM) = "01"			Claim Billing
<i>Field</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
304-C4	DATE OF BIRTH		R	
305-C5	PATIENT GENDER CODE		R	
310-CA	PATIENT FIRST NAME		RW	<i>Imp Guide:</i> Required when the patient has a first name. <i>Payer Requirement:</i> Required as all patients are enrolled with a first name. If newborn, use "BABY BOY" or "BABY GIRL." If person has only one name, put one name in this field.
311-CB	PATIENT LAST NAME		R	

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

	Claim Segment Segment Identification (111-AM) = "07"			Claim Billing
<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 = Rx Billing	M	<i>Imp Guide:</i> For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	01 = Universal Product Code (UPC) 03 = National Drug Code (NDC)	M	
407-D7	PRODUCT/SERVICE ID		M	
442-E7	QUANTITY DISPENSED		R	
403-D3	FILL NUMBER		R	
405-D5	DAYS SUPPLY		R	

Claim Segment Segment Identification (111-AM) = "07"			Claim Billing	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
406-D6	COMPOUND CODE	01 = Not a Compound 02 = Compound See Compound Segment for support of multi-ingredient compounds	R	
408-D8	DISPENSE AS WRITTEN (DAW/PRODUCT SELECTION CODE)	All values supported.	R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	Imp Guide: Required if Submission Clarification Code (420-DK) is used. Payer Requirement: Same as Imp Guide.
420-DK	SUBMISSION CLARIFICATION CODE	All values supported.	RW	Imp Guide: Required if clarification is needed and value submitted is greater than zero (0). If the Date of Service (401-D1) contains the subsequent payer coverage date, the Submission Clarification Code (420-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: Required when claim explanation is needed for overrides.
308-C8	OTHER COVERAGE CODE	All values supported.	RW	Imp Guide: Required if needed by receiver, to communicate a summation of other coverage information collected from other payers. Required for Coordination of Benefits. Payer Requirement: Only used in COB claims.
995-E2	ROUTE OF ADMINISTRATION		RW	Imp Guide: Required if specified in trading partner agreement. Payer Requirement: Required when Compound Code (406-D6) = 2 (compound).

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

Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	INGREDIENT COST SUBMITTED		R	
430-DU	GROSS AMOUNT DUE		R	
412-DC	DISPENSING FEE SUBMITTED		RW	Imp Guide: Required if its value effects the Gross Amount Due (430-DU) calculation. Payer Requirement: Same as Imp Guide.
426-DQ	USUAL AND CUSTOMARY CHARGE		RW	Imp Guide: Required if needed per trading partner agreement. Payer Requirement: Required.

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted Qualifier (479-H8) is used. <i>Payer Requirement: Same as Imp Guide.</i>
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	01 = Delivery cost 04 = Administrative cost	RW	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted (480-H9) is used. <i>Payer Requirement: Same as Imp Guide.</i>
480-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	<i>Imp Guide:</i> Required if its value effects the Gross Amount Due (430-DU) calculation. <i>Payer Requirement: Required for values listed.</i>
423-DN	BASIS OF COST DETERMINATION		RW	<i>Imp Guide:</i> Required if needed for receiver claim/encounter adjudication. <i>Payer Requirement: Required.</i>

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

	Prescriber Segment Segment Identification (111-AM) = "03"			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	01 = National Provider ID 08 = State License (if prescriber does not have an NPI or NPI is not known)	RW	<i>Imp Guide:</i> Required if Prescriber ID (411-DB) is used. <i>Payer Requirement: Required to be either value on all claims.</i>
411-DB	PRESCRIBER ID		RW	<i>Imp Guide:</i> Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement: Required when the Prescriber ID Qualifier is sent.</i>

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>Required only for secondary, tertiary, etc. claims.</i>
Scenario 1 - Other Payer Amount Paid Repetitions Only		
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only	X	<i>Required when Other Coverage Code = 8 (Claim is billing for patient financial responsibility)</i>
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount and Benefit Stage Repetitions Present (Government Programs)		

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"			Claim Billing
				Scenario 2- Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only

NCPDP Payer Sheet Template

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	All values supported.	M	
339-6C	OTHER PAYER ID QUALIFIER	03 = BIN	RW	Imp Guide: Required if Other Payer ID (340-7C) is used. Payer Requirement: Required when claim has been paid or rejected by previous payer(s).
340-7C	OTHER PAYER ID		RW	Imp Guide: Required if identification of the Other Payer is necessary for claim/encounter adjudication. Payer Requirement: Required when claim has been paid or rejected by previous payer(s).
443-E8	OTHER PAYER DATE		RW	Imp Guide: Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. Payer Requirement: Required when claim has been paid or rejected by previous payer(s).
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	Imp Guide: Required if Other Payer Reject Code (472-6E) is used. Payer Requirement: Required when claim has been rejected by previous payer(s).
472-6E	OTHER PAYER REJECT CODE		RW	Imp Guide: Required when the other payer has denied the payment for the billing. Payer Requirement: Required when claim has been rejected by previous payer(s).
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	Imp Guide: Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. Payer Requirement: Same as Imp Guide.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		RW	Imp Guide: Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. Payer Requirement: Same as Imp Guide.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	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. Payer Requirement: Required.

Compound Segment Questions	Check	Claim Billing 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	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	All values supported.	M	

	Compound Segment Segment Identification (111-AM) = "10"			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	All values supported.	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum of 25 ingredients.	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	01 = Universal Product Code (UPC) 03 = National Drug Code DC)	M	Payer Requirement: Maximum of 10 ingredients.
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.

** End of Request Claim Billing (B1) Payer Sheet Template**

10.1.3.2 NON-WORKERS' COMPENSATION CLAIM BILLING ACCEPTED/PAID (OR DUPLICATE OF PAID) RESPONSE

** Start of Response Claim Billing (B1) Payer Sheet Template**

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

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

	Response Transaction Header Segment			Claim Billing – Paid (Duplicate of Paid)
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	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

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

	Response Message Segment Segment Identification (111-AM) = "20"			Claim Billing – Paid (Duplicate of aid)
Field #	NCPDP Field Name	Value	Payer Usage	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.

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Response Patient Segment Questions	Check	Claim Billing Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Will be returned as verification

	Response Patient Segment Segment Identification (111-AM) = "29"			Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME		RW	Imp Guide: Payer Requirement: Will be sent every time.
311-CB	PATIENT LAST NAME		RW	Imp Guide: Payer Requirement: Will be sent every time.
304-C4	DATE OF BIRTH		RW	Imp Guide: Payer Requirement: Will be sent every time.

Response Status Segment Questions	Check	Claim Billing 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 – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
503-F3	AUTHORIZATION NUMBER		RW	Imp Guide: Required if needed to identify the transaction. Payer Requirement: Will contain the trace back number of the claim.
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.	RW	Imp Guide: Required if Approved Message Code (548-6F) is used. Payer Requirement: Same as Imp Guide.
548-6F	APPROVED MESSAGE CODE		RW	Imp Guide: Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. 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	01 = Used for first line of free form text with no pre-defined structure. 02 = 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.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Imp Guide: Required when additional text is needed for clarification or detail. Payer Requirement: Will be returned.

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Response Status Segment Segment Identification (111-AM) = "21"				Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	Imp Guide: Required if Help Desk Phone Number (550-8F) is used. Payer Requirement: Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	Imp Guide: Required if needed to provide a support telephone number to the receiver. Payer Requirement: Will be returned.

Response Claim Segment Questions	Check	Claim Billing 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 – Paid (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).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response Pricing Segment Questions	Check	Claim Billing 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 – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID		RW	Imp Guide: Required if this value is used to arrive at the final reimbursement. Payer Requirement: Same as Imp Guide. And, if submitted, will be returned.
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 Imp Guide.
558-AW	FLAT SALES TAX AMOUNT PAID		RW	Imp Guide: Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (0) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement. Payer Requirement: Same as Imp Guide.

	Response Pricing Segment Segment Identification (111-AM) = "23"			Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		RW	<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 (0).</p> <p>Required if Percentage Sales Tax Rate Paid (560-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used.</p> <p><i>Payer Requirement: Same as Imp Guide.</i></p>
560-AY	PERCENTAGE SALES TAX RATE PAID		RW	<p><i>Imp Guide:</i> Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (0).</p> <p><i>Payer Requirement: Same as Imp Guide.</i></p>
561-AZ	PERCENTAGE SALES TAX BASIS PAID		RW	<p><i>Imp Guide:</i> Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (0).</p> <p><i>Payer Requirement: Same as Imp Guide.</i></p>
521-FL	INCENTIVE AMOUNT PAID		RW	<p><i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.</p> <p>Required if Incentive Amount Submitted (438-E3) is greater than zero (0).</p> <p><i>Payer Requirement: Same as Imp Guide.</i></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	01 = Delivery cost 04 = Administrative cost	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 (480-H9) is greater than zero (0).</p> <p><i>Payer Requirement: Will be returned when submission includes Other Amount Claimed Submitted.</i></p>
509-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		RW	<p><i>Imp Guide:</i> Required if Ingredient Cost Paid (506-F6) is greater than zero (0).</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>

	Response Pricing Segment Segment Identification (111-AM) = "23"			Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes deductible <i>Payer Requirement: Same as Imp Guide.</i>
575-EQ	PATIENT SALES TAX AMOUNT		RW	<i>Imp Guide:</i> Used when necessary to identify the Patient's portion of the Sales Tax. <i>Payer Requirement: Same as Imp Guide.</i>
574-2Y	PLAN SALES TAX AMOUNT		RW	<i>Imp Guide:</i> Used when necessary to identify the Plan's portion of the Sales Tax. Provided for informational purposes only. <i>Payer Requirement: Same as Imp Guide.</i>
572-4U	AMOUNT OF COINSURANCE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes coinsurance as patient financial responsibility. <i>Payer Requirement: Same as Imp Guide.</i>
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a Brand drug. <i>Payer Requirement: Same as Imp Guide.</i>
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a non-preferred formulary product. <i>Payer Requirement: Same as Imp Guide.</i>
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a Brand non-preferred formulary product. <i>Payer Requirement: Same as Imp Guide.</i>

Response DUR/PPS Segment Questions	Check	Claim Billing Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>This segment will be transmitted when a possible conflict is detected.</i>

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

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	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
529-FT	OTHER PHARMACY INDICATOR	All values supported.	RW	Imp Guide: Required if needed to supply additional information for the utilization conflict. Payer Requirement: Same as Imp Guide.
530-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 Imp 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 (530-FU) is used. Payer Requirement: Same as Imp Guide.
532-FW	DATABASE INDICATOR	All values supported.	RW	Imp Guide: Required if needed to supply additional information for the utilization conflict. Payer Requirement: Same as Imp Guide.
533-FX	OTHER PRESCRIBER INDICATOR	All values supported.	RW	Imp Guide: Required if needed to supply additional information for the utilization conflict. Payer Requirement: Same as Imp 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 Imp Guide.
570-NS	DUR ADDITIONAL TEXT		RW	Imp Guide: Required if Reason For Service Code (439-E4) is used. Payer Requirement: Same as Imp Guide.

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Will be returned when other payers involved.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Claim Billing – Paid (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	All values supported.	M	
339-6C	OTHER PAYER ID QUALIFIER	03 = BIN	RW	Imp Guide: Required if Other Payer ID (340-7C) is used. Payer Requirement: Same as Imp Guide.
340-7C	OTHER PAYER ID		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Claim Billing – Paid (Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
356-NU	OTHER PAYER CARDHOLDER ID		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	Imp Guide: Required if needed to provide a support telephone number of the other payer to the receiver. Payer Requirement: Same as Imp Guide.

10.1.3.3 NON-WORKERS' COMPENSATION CLAIM BILLING ACCEPTED/REJECTED RESPONSE

CLAIM BILLING ACCEPTED/REJECTED RESPONSE

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

	Response Transaction Header Segment			Claim Billing – Accepted/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	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing 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.

	Response Message Segment Segment Identification (111-AM) = "20"			Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	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 Patient Segment Questions	Check	Claim Billing Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Will be returned if patient can be found.

	Response Patient Segment Segment Identification (111-AM) = "29"			Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

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	Response Patient Segment Segment Identification (111-AM) = "29"			Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME		RW	Imp Guide: Payer Requirement: Will be sent if patient can be found.
311-CB	PATIENT LAST NAME		RW	Imp Guide: Payer Requirement: Will be sent if patient can be found.
304-C4	DATE OF BIRTH		RW	Imp Guide: Payer Requirement: Will be sent if patient can be found.

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

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing – Accepted/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	Imp Guide: Required if a repeating field is in error, to identify repeating field occurrence. Payer Requirement: Only sent if reject is on a field that has multiple occurrences.
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	01 = Used for first line of free form text with no pre-defined structure. 02 = 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.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Imp Guide: Required when additional text is needed for clarification or detail. Payer Requirement: Will be returned.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	Imp Guide: Required if Help Desk Phone Number (550-8F) is used. Payer Requirement: Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	Imp Guide: Required if needed to provide a support telephone number to the receiver. Payer Requirement: Will be returned.
987-MA	URL		RW	Imp Guide: Provided for informational purposes only to relay health care communications via the Internet. Payer Requirement: Will be returned.

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

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	<i>Imp Guide:</i> For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
551-9F	PREFERRED PRODUCT COUNT	Maximum count of 6.	RW	<i>Imp Guide:</i> Required if Preferred Product ID (553-AR) is used. <i>Payer Requirement:</i> Preferred fields will be sent on a reject when there is a preferred product per the health plan's formulary.
552-AP	PREFERRED PRODUCT ID QUALIFIER	03 = National Drug Code (NDC)	RW	<i>Imp Guide:</i> Required if Preferred Product ID (553-AR) is used. <i>Payer Requirement:</i> Same as Imp Guide.
553-AR	PREFERRED PRODUCT ID		RW	<i>Imp Guide:</i> Required if a product preference exists that needs to be communicated to the receiver via an ID. <i>Payer Requirement:</i>
554-AS	PREFERRED PRODUCT INCENTIVE		RW	<i>Imp Guide:</i> Required if there is a known incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU). <i>Payer Requirement:</i> Same as Imp Guide.
555-AT	PREFERRED PRODUCT COST SHARE INCENTIVE		RW	<i>Imp Guide:</i> Required if there is a known patient financial responsibility incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU). <i>Payer Requirement:</i> Same as Imp Guide.
556-AU	PREFERRED PRODUCT DESCRIPTION		RW	<i>Imp Guide:</i> 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). <i>Payer Requirement:</i> Same as Imp Guide.

Response DUR/PPS Segment Questions	Check	Claim Billing Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>This segment will be transmitted on a reject when a possible conflict is detected.</i>

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used. <i>Payer Requirement: Same as Imp Guide.</i>
439-E4	REASON FOR SERVICE CODE	All values supported.	RW	<i>Imp Guide:</i> Required if utilization conflict is detected. <i>Payer Requirement: Same as Imp Guide.</i>
528-FS	CLINICAL SIGNIFICANCE CODE	All values supported.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement: Same as Imp Guide.</i>
529-FT	OTHER PHARMACY INDICATOR	All values supported.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement: Same as Imp Guide.</i>
530-FU	PREVIOUS DATE OF FILL		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. <i>Payer Requirement: Same as Imp Guide.</i>
531-FV	QUANTITY OF PREVIOUS FILL		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (530-FU) is used. <i>Payer Requirement: Same as Imp Guide.</i>
532-FW	DATABASE INDICATOR	All values supported.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement: Same as Imp Guide.</i>
533-FX	OTHER PRESCRIBER INDICATOR	All values supported.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement: Same as Imp Guide.</i>
544-FY	DUR FREE TEXT MESSAGE		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement: Same as Imp Guide.</i>
570-NS	DUR ADDITIONAL TEXT		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. <i>Payer Requirement: Same as Imp Guide.</i>

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Will be sent if other payers known.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE	All values supported.	M	

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Claim Billing – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
339-6C	OTHER PAYER ID QUALIFIER	03 = BIN	RW	Imp Guide: Required if Other Payer ID (340-7C) is used. Payer Requirement: Same as Imp Guide.
340-7C	OTHER PAYER ID		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
356-NU	OTHER PAYER CARDHOLDER ID		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	Imp Guide: Required if needed to provide a support telephone number of the other payer to the receiver. Payer Requirement: Same as Imp Guide.

10.1.3.4 NON-WORKERS' COMPENSATION CLAIM BILLING REJECTED/REJECTED RESPONSE

CLAIM BILLING REJECTED/REJECTED RESPONSE

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

Field #	Response Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Billing – Rejected/Rejected 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 Segment Questions	Check	Claim Billing 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.

	Response Message Segment Segment Identification (111-AM) = "20"			Claim Billing – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	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.

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

Field #	Response Status Segment Segment Identification (111-AM) = "21"	Value	Payer Usage	Claim Billing – Rejected/Rejected Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Reject Codes	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	01 = Used for first line of free form text with no pre-defined structure. 02 = 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.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Imp Guide: Required when additional text is needed for clarification or detail. Payer Requirement: Will be returned.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	Imp Guide: Required if Help Desk Phone Number (550-8F) is used. Payer Requirement: Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	Imp Guide: Required if needed to provide a support telephone number to the receiver. Payer Requirement: Will be returned.

** End of Response Claim Billing (B1) Payer Sheet Template**

10.1.4 NON-WORKERS' COMPENSATION CLAIM REVERSAL

This is a continuation of the example of a payer sheet for a plan with information about claims reversals for the non-workers' compensation plan. The payer sheet shows an approved and a rejected response.

10.1.4.1 NON-WORKERS' COMPENSATION CLAIM REVERSAL REQUEST

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

GENERAL INFORMATION

Payer Name: ABC, Inc.	Date: 01/01/2010
Plan Name/Group Name: General Health Plan	BIN: 882211 PCN: Blank fill

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

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Payer Usage Column	Value	Explanation	Payer Situation Column
QUALIFIED REQUIREMENT	RW	"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?)	90 days

CLAIM REVERSAL TRANSACTION

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

	Transaction Header Segment			Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN NUMBER	882211	M	BIN for General Health Plan
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	Claim Reversal
104-A4	PROCESSOR CONTROL NUMBER	Blank fill	M	Blank fill
109-A9	TRANSACTION COUNT	01 = One occurrence 02 = Two occurrences 03 = Three occurrences 04 = Four occurrences	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M	
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill

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

	Insurance Segment Segment Identification (111-AM) = "04"			Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	Member's ID as shown on card.

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

	Claim Segment Segment Identification (111-AM) = "07"			Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

Claim Segment Segment Identification (111-AM) = "07"			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).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	01 = Universal Product Code (UPC) 03 = National Drug Code (NDC)	M	
407-D7	PRODUCT/SERVICE ID		M	
403-D3	FILL NUMBER		RW	<i>Imp Guide:</i> Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (402-D2) occur on the same day. <i>Payer Requirement:</i> Same as Imp Guide.
308-C8	OTHER COVERAGE CODE	1 = No other coverage 2 = Other coverage exists – payment collected 8 = Claim is billing for patient financial responsibility only	RW	<i>Imp Guide:</i> Required if needed by receiver to match the claim that is being reversed. <i>Payer Requirement:</i> Only used in COB claims.

Pricing Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>Segment is sent if contract to provider allows for incentive.</i>

Pricing Segment Segment Identification (111-AM) = "11"			Claim Reversal	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	<i>Imp Guide:</i> Required if this field could result in contractually agreed upon payment. <i>Payer Requirement:</i> Submit based on contracted agreement.
430-DU	GROSS AMOUNT DUE		RW	<i>Imp Guide:</i> Required if this field could result in contractually agreed upon payment. <i>Payer Requirement:</i> If Incentive is sent, this field must be sent.

** End of Request Claim Reversal (B2) Payer Sheet Template**

10.1.4.2 NON-WORKERS' COMPENSATION CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

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

GENERAL INFORMATION

Payer Name: ABC, Inc.	Date: 01/01/2010
Plan Name/Group Name: General Health Plan	BIN: 882211 PCN: Blank fill

CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

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

Response Transaction Header Segment	Claim Reversal – Accepted/Approved
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NCPDP Payer Sheet Template

Field #	NCPDP Field Name	Value	Payer Usage	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 Status Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, Payer Situation
This Segment is always sent	X	

Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	
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.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Maximum count of 2 will be returned.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	01 = Used for first line of free form text with no pre-defined structure. 02 = Used for second line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used. <i>Payer Requirement:</i> Only qualifier values cited will be returned.
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used. <i>Payer Requirement:</i> Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver. <i>Payer Requirement:</i> Will be returned.

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

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

Response Pricing Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Will be returned when submission includes incentive.</i>

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

10.1.4.3 NON-WORKERS' COMPENSATION CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

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

	Transaction Header Segment			Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	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 Segment Questions	Check	Claim Reversal - Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Will be returned on rejected claims when the error is at transmission-level.</i>

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

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

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Accepted/Rejected
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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	NCPDP Reject Codes	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<p><i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence.</p> <p><i>Payer Requirement:</i> Only sent if reject is on a field that has multiple occurrences.</p>
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<p><i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.</p> <p><i>Payer Requirement:</i> Maximum count of 2 will be returned.</p>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	<p>01 = Used for first line of free form text with no pre-defined structure</p> <p>02 = Used for second line of free form text with no pre-defined structure.</p>	RW	<p><i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.</p> <p><i>Payer Requirement:</i> Only qualifier values cited will be returned.</p>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<p><i>Imp Guide:</i> Required when additional text is needed for clarification or detail.</p> <p><i>Payer Requirement:</i> Will be returned.</p>
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	<p><i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used.</p> <p><i>Payer Requirement:</i> Will be returned.</p>
550-8F	HELP DESK PHONE NUMBER		RW	<p><i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.</p> <p><i>Payer Requirement:</i> Will be returned.</p>

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

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

10.1.4.4 NON-WORKERS' COMPENSATION CLAIM REVERSAL REJECTED/REJECTED RESPONSE

CLAIM REVERSAL REJECTED/REJECTED RESPONSE

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

Response Transaction Header Segment		Claim Reversal – Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	Claim Reversal
109-A9	TRANSACTION COUNT	Same value as in request	M	

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NCPDP Payer Sheet Template

Response Transaction Header Segment				Claim Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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.

Response Message Segment Segment Identification (111-AM) = "20"				Claim Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	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	

Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Reject Codes	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: Only sent if reject is on a field that has multiple occurrences.
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	01 = Used for first line of free form text with no pre-defined structure 02 = 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.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Imp Guide: Required when additional text is needed for clarification or detail. Payer Requirement: Will be returned.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	Imp Guide: Required if Help Desk Phone Number (550-8F) is used. Payer Requirement: Will be returned.
550-8F	HELP DESK PHONE NUMBER		RW	Imp Guide: Required if needed to provide a support telephone number to the receiver. Payer Requirement: Will be returned.

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**** End of Claim Reversal (B2) Response Payer Sheet Template****

11. EXAMPLE 4 – AMERICAN PROCESSOR INC PAYER SHEET - MULTIPLE PLANS

One payer (American Processor Inc) with multiple plans (General Plan A, B, C and D) that all have the same requirements may use the same payer template. (If this processor supports multiple plans (different BINs and/or PCNs) that cause different segments to be used, multiple payer templates must be created for each unique combination (see section [Plan Differentiation](#)).

11.1.1 CLAIM BILLING/CLAIM REBILL

11.1.1.1 CLAIM BILLING/CLAIM REBILL REQUEST

This is an excerpt showing just the General Information section of the payer sheet. The payer sheet shows how this payer would expect to receive a standard request and how the payer would respond.

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

GENERAL INFORMATION

Payer Name: American Processor Inc	Date: 01/01/2010	
Plan Name/Group Name: General Plan A	BIN: 551100	PCN: Blank fill
Plan Name/Group Name: General Plan B	BIN: 551122	PCN: Blank fill
Plan Name/Group Name: General Plan C	BIN: 552211	PCN: Blank fill
Plan Name/Group Name: General Plan D	BIN: 552288	PCN: Blank fill
Processor: American Processor Inc.		
Effective as of: 07/01/2010	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: 07/2007	NCPDP External Code List Version Date: 01/2008	
Contact/Information Source: Provider Manuals available at www.americanprocessor.com/providermanuals, General website www.americanprocessor.com		
Certification Testing Window: Monday-Friday 8 am ET – 5 pm ET		
Certification Contact Information: 888-111-3333 Certification packet available		
Provider Relations Help Desk Info: Pharmacy Help Desk: 888-555-1222 Physician Help Desk: 888-555-4444		
Other versions supported:		

The payer sheet information would follow. All the plans for this processor use the same requirements (such as Example 1 above).

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

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12. FREQUENTLY ASKED QUESTIONS

12.1 *USE OF RED FONT*

Question: Does the red font shown in the payer templates need to be used by the industry?

Response: No. The red font is shown in this guide as a tool for understanding how to prepare the payer template correctly.

12.2 *FONT SIZE*

Question: Do the payer templates need to be use the small font shown?

Response: No. The small font shown in this guide is only to minimize the size of this document. Actual payer templates should use larger font sizes for readability.

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13. APPENDIX A. HISTORY OF IMPLEMENTATION GUIDE CHANGES

13.1 EDITORIAL CORRECTIONS

Field DUR Additional Text (570-NS) was inadvertently left off the Response DUR/PPS Segment in section *“Non-Workers’ Compensation Claim Billing Accepted/Paid (Or Duplicate of Paid) Response”*.

The Prescription/Service Reference Number Qualifier (455-EM) values were used inconsistently throughout the documents and were modified to reflect ‘1’ for Rx Billing and ‘2’ for Service Billing.

The word “Header” was removed from the Response Insurance Segment and the Response Message Segment references to correctly reflect the name of the segment.

13.2 VERSION 1.1 CORRECTIONS

The field Scheduled Prescription ID Number (454-EK) was changed from Not Used to Situational and added to the Claim Segment.

13.3 VERSION 1.2

Response Insurance Segment in section *“Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) Response”* inadvertently included an X in the Response Insurance Segment Questions. It has been removed.

Section *“Vaccine Administration”* was added to *“Specific Topic Discussion”*.

13.1 VERSION 1.3

The Response Pricing Segment on the paid responses in examples now includes the two-tax amount paid fields. Since the requirement in the Implementation Guide is that the field must be returned if the pharmacy submitted anything greater than zero in the corresponding fields of the Request Pricing Segment, it is necessary to include these fields in every payer sheet since it isn’t possible to know when the pharmacy will submit tax amounts, even if the plan will not determine any payment is due. Per the Implementation Guide, the plan is to reference that the fields will always be returned with a zero amount if the corresponding request was submitted, but they cannot ignore it and remove it from the payer sheet. The informational plan and payer sales tax fields have been added also.

In sections *“Claim Billing/Claim Rebill Accepted/Rejected Response”* and *“Claim Billing/Claim Rebill Rejected/Rejected Response”* Authorization Number (503-F3) was inadvertently marked “RW” in Payer Usage. The column has removed this designation as it would be used in examples, not the template.

13.2 VERSION 1.4

The situation on Other Payer Reject Code (472-6E) has been clarified from “Required when the payer in this occurrence has denied the payment for the billing, designated with Other Coverage Code (308-C8) = 3 (Other Coverage Billed – claim not covered)” to “Required when the payer in this occurrence has denied the payment for the billing.” The reference to Other Coverage Code value of 3 caused an assumption that Other Coverage Code must be 3. This was modified in Telecom Version D.9. The Other Coverage Code chart in the Telecom Version D.9 was also updated. This has been updated in this document just to negate confusion.

13.3 VERSION 1.5

Important: Based on industry request, an enhancement was made to Telecommunication Standard Implementation Guide Version D.0 for Quantity Prescribed (460-ET). NCPDP has published an enhancement of the Telecommunication Standard Implementation Guide Version D.0. The enhanced guide contains a publication date of “November 2012”. In the guide in section *“Appendix A. History of Document Changes,” “Version D.0,” “November 2012 Enhancement”*, an entry appears. NCPDP provided a request to the Office of e-Health Standards and Services to publish regulatory notice about the implementation guide enhancement. See http://www.ncpdp.org/news_hipaa_trans_current.aspx under Implementation Guide Enhancements for updates to this action.

13.4 VERSION 16 MAY 2020

The usage statement on the title page was updated.

The following sections of the Payer Sheet Template were updated to reflect the use of the Quantity Prescribed field (460-ET) as a result of the Quantity Prescribed final rule CMS-0055-F published on January 24, 2020.

- [General Information For A Payer About the Templates](#)
- [Situations on Fields](#)

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- [Specific Topic Discussions](#)
 - New section: [Quantity Prescribed \(460-ET\)](#) was added causing remaining subsections to be renumbered
- [Not Used Fields](#)
- [Request Claim Billing/Claim Rebill Payer Sheet Template](#), Claim Segment

13.5 VERSION 17 MARCH 2022

- Updated Sections 2.3 and 2.6.3 to provide clarity regarding the need for one payer sheet per COB method
- Section 4.1 Added line items to Coordination of Benefits/Other Payer Segment Questions to indicate the segment is not supported and to provide a place for optional additional COB processing information.

13.6 VERSION 18 SEPTEMBER 2024

- Section 4.1
 - Updated NCPDP Telecommunication Standard Version/Release # to D.0
- Section 9: Example 2
 - Removed “Service Rebill” and “S3” throughout
 - Added clarification that service rebill transactions are not supported
- Section 9.1.1.1
 - Removed “Service Rebill” and “S3” throughout
 - Removed Claim Rebill from Other Transactions Supported table
 - Added comment to Transaction Count (109-A9)
 - Updated the payer requirement to “Required” and updated reference to where the Cardholder ID can be found for Person Code (303-C3) and Group ID (301-C1)
 - Removed “All values supported” or all the values listed in the value column for the following fields
 - Patient Gender Code (305-C5)
 - Place of Service (307-C7)
 - Reason for Service Code (439-E4)
 - Professional Service Code (440-E5)
 - Result of Service Code (441-E6)
 - DUR/PPS Level of Effort (474-8E)
 - Updated the payer requirement to “Same as Imp Guide” for the following fields
 - Patient First Name (310-CA)
 - Reason for Service Code (439-E4)
 - Professional Service Code (440-E5)
 - Result of Service Code (441-E6)
 - DUR/PPS Level of Effort (474-8E)
 - Diagnosis Code (424-DO)
 - Updated Payer Requirement from “Required for values listed” to “Required to indicate the setting in which the service was provided.”
 - Added Patient Residence (384-4X)
 - Removed Claim Segment Questions relevant to partial fills from Claim Segment Questions table
 - Updated values from 06 = DUR/PPS to 07 = CPT4 and 09 = HCPCS and added payer requirement in the payer situation column for Product/Service ID Qualifier (436-E1)
 - Added Pharmacy Service Type (147-U7)
 - Added Pharmacy Provider Segment and Prescriber Segment
 - Changed DUR/PPS Segment Questions and Clinical Segment Questions to situational and added payer requirement
 - Updated value 01 = ICD9 to 02 = ICD10 for Diagnosis Code Qualifier (492-WE)
- Section 9.1.1.2
 - Removed “Service Rebill” and “S3” throughout
 - Removed payer requirement from payer situation column for the following fields
 - Additional Message Information Count (130-UF)
 - Additional Message Information Qualifier (132-UH)
 - Removed value for Additional Message Information Qualifier (132-UH)
 - Added Response DUR/PPS segment
- Section 9.1.1.3
 - Removed “Service Rebill” and “S3” throughout
 - Removed payer requirement from payer situation column for the following fields
 - Additional Message Information Count (130-UF)
 - Additional Message Information Qualifier (132-UH)
 - Removed value for Additional Message Information Qualifier (132-UH)
 - Removed Response DUR/PPS segment
- Section 9.1.1.4

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- Removed “Service Rebill” and “S3” throughout
- Removed payer requirement from payer situation column for the following fields
 - Additional Message Information Count (130-UF)
 - Additional Message Information Qualifier (132-UH)
- Removed value for Additional Message Information Qualifier (132-UH)
- Added the following sections
 - Section 9.1.2 Service Reversals
 - Section 9.1.2.1 Service Reversal Request
 - Section 9.1.2.2 Service Reversal Accepted/Approved Response
 - Section 9.1.2.3 Service Reversal Accepted/Rejected Response
 - Section 9.1.2.4 Service Reversal Rejected/Rejected Response

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