Telecommunication Standard Version F6© and above Editorial and Best Practices

DOCUMENTATION

September 2026

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Telecommunication Standard Version F6© and Above Editorial and Best Practices

Version 04

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1. PURPOSE OF THIS DOCUMENT

This document provides a consolidated reference point for questions that have been posed based on the review and implementation of the NCPDP Telecommunication Standard Implementation Guide Version F6© and above, the Data Dictionary©, and the External Code List©. This document also addresses editorial changes made to these documents.

As stakeholders reviewed the documents, questions arose which were not specifically addressed in the guides or could be clarified further. These questions were addressed in the Work Group 1 Telecommunication meetings.

Editorial corrections include typographical errors, comments that do not match a field value or a reference pointer in error. Clarifications that affect implementation of the Telecommunication Standard Implementation Guide Version F6© will be cited in this document.

NCPDP Telecommunication Standard Implementation Guide Version F6© was named in Final Rule published December 13, 2024 for the Health Insurance Portability and Accountability Act (HIPAA).

It should be noted that values may be added/changed/deleted in the External Code List© on a quarterly basis. This allows the industry to adapt to business needs when values are needed.

The document is split into three sections – Editorial, Best Practices and General. Questions and the associated answers in the Editorial section must be implemented. Questions and answers in the Best Practices section are generally accepted guidelines. The General section contains questions and answers which are applicable to the Editorial section and the Best Practices section. Topics are in categories which provide a high-level reference. For example, a category may be a Segment in the format, with a subcategory of a field in that segment. The question and answer is then posed for that field found in that segment. Where appropriate, the question may be the actual heading in the index for ease of research.

This document will continue to be updated as questions and answers or editorial changes are necessary.

Note: within the guide, when dollar fields and amounts are discussed, all digits may be seen for readability. When actually using the field, rules should be followed for the overpunch character, as applicable.

1.1 Use Of This Document

This document should be used as a reference for the Telecommunication Standard Implementation Guide Version F6© and above, the Batch Standard Implementation Guide Version 15© and the Batch Standard Subrogation Implementation Guide Version 10© as applicable. In the Batch Standard© and the Batch Standard Subrogation Implementation Guide© (when used in batch mode), the Detail Data Record consists of the NCPDP Data Record, which consists of the Telecommunication Standard© record format. Therefore, references in these documents apply to all three standards as applicable.

1.1.1 Supporting This Document

Question:
Once the Telecommunication Standard Version F6© and Above Editorial and Best Practices (Version F6 Editorial) is published, how soon do implementers need to support it?

Answer:

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When the Version F6 Editorial is published, it is effective for use *immediately unless the specific section or response lists an effective date*.

1.2 External Code List© (ECL) Information

Please review the *Overview External Code List© (ECL) Process and Telecom Emergency/Script and Specialized Expedited ECL Processes* document at https://standards.ncpdp.org/Standards/media/pdf/ECLProcessOverview.pdf

This document provides the process to request additions, modifications, and deletions to the data element values existing in the External Code List© (ECL). It provides the rules governing the procedures and steps for this process and maintenance of the ECL as approved by the NCPDP Board of Trustees. In addition, this document outlines the Telecommunication ECL implementation timetable used to facilitate consistency across the industry.

This document contains an ECL Publication and Implementation Chart to provide key dates in which full ECL Publications and ECL Emergency Values should be implemented across all industry participants supporting the NCPDP Telecommunication Standard©.

The *Emergency Telecommunication External Code List© Value Addendum* located at https://stds.ncpdp.org/ExternalCodeList/ provides a list of values approved for emergency implementation.

1.3 NCPDP Emergency Preparedness Resource

The *NCPDP Emergency Preparedness Guidance* document provides guidance for the pharmacy industry for resources available during a declared emergency. The intended audience is healthcare industry providers who would need resource information for eligibility and claims processing affecting displaced individuals. It is available at https://ncpdp.org/Resources under the Emergency Preparedness Topic.

1.4 NDC

At the time of publication of the Telecommunication Standard Version F6©, the mandated NDC was 11 digits. Since then, the FDA Final Rule *"Revising the National Drug Code Format and Drug Label Barcode Requirements"* has been promulgated with an NDC of 12 digits; therefore, any references to an 11-digit NDC should be treated as a 12-digit NDC as of the mandated FDA Final Rule implementation date of March 7, 2033.

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2. EDITORIAL CORRECTIONS

2.1 Telecommunication Standard Version F6©

- Section 35.61 - *VERSION F6 JULY 2024 REPUBLICATION:* the field identifier for Other Payer Adjudicated Program Type should be C47-9T. The reference to Other Payer Adjudicated Type should be Other Payer Adjudicated Program Type with a field identifier of C47-9T.

- Even though the field Patient ID Associated State/Province Address (A22-YR) appears in the implementation guide as Not Used, the field should have been deleted from the implementation guide. Refer to DERF 1854.

- Formulary Alternative Required Therapy Indicator Count (D44-P0) does not repeat. The field should be listed in the implementation guide as Q, not Q***R***, N, not N***R*** or S***R***. This correction applies to the following sections:

10.5.1.2.6	10.5.2.2.6	10.5.3.2.6	12.4.1.2.6	12.4.2.2.6	12.4.3.2.6
13.5.1.2.4	13.5.2.2.4	13.5.3.2.4	13.8.1.2.4	13.8.2.2.4	13.8.3.2.4
14.4.1.2.6	14.4.2.2.6	14.4.3.2.6	14.7.1.2.6	14.7.2.2.6	14.7.3.2.6
16.3.1.2.6	16.3.2.2.6	16.3.3.2.6	16.3.4.2.6	18.3.1.2.6	18.3.3.2.5
18.3.4.2.5	18.3.5.2.5	19.3.1.2.5	19.3.2.2.5	19.3.3.2.5	19.3.4.2.5
21.4.1.2.6	21.4.2.2.6	21.4.3.2.6	22.5.1.2.4	22.5.2.2.4	22.5.3.2.4
23.4.1.2.6	23.4.2.2.6	23.4.3.2.6	25.2.2		

- Subrogation Requestors Reconciliation ID (D15-KY) is required for subrogation. It should be listed as RM, not QM. This correction applies to the following sections:
    - 10.5.1.2.6.1 Response Claim Segment (Subrogation Standard Claim Billing or Encounter) (Transmission Accepted/Transaction Paid)
    - 10.5.3.2.6.1 Response Claim Segment (Subrogation Standard Claim Billing or Encounter) (Transmission Accepted/Transaction Rejected)
    - 14.4.1.2.6.1 Response Claim Segment (Subrogation Standard Claim Rebill) (Transmission Accepted/Transaction Paid)

- Section 7.13.1.1 – Count Fields
    - Other Payer Reconciliation ID: The Other Payer Reconciliation ID (C49-9V) would not be reported when the COB occurrence is reporting a rejected response from the previous payer, represented by the values submitted in the Other Payer Reject Code (472-6E) field.

- Section 28.3.3.2 includes two references to Amount Attributed to Processor Fee (571-NZ) that was used in Version D.0 but removed before Version F6. The value previously populated in that field should now be populated in Patient Pay Component Qualifier (C95-KQ) value 13 – *Amount Attributed to Processor Fee* and Patient Pay Component Amount (C93-KN).

Added March 2026

- Section 35.23 Version EB April 2017, is missing the word “have” in the 40th paragraph. It should read, “Added two fields, Benefit Type Opportunity Count (C59-AF) and Benefit Type

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Opportunity (C58-AE), to the Response Claim Segment to provide additional information on the patient's benefit. This was done to promote transparence of plan benefit information allowing the patient to take advantage of areas of their plan benefit they may have been unaware of."

Added March 2026

- Section 26.3.5.1.2 Capture Consistency and Section 28.2 COB Methods and Other Coverage Code Values use an incorrect field ID for the Processor Control Number. The correct field ID is 104-A4.

Added March 2026

- Section 10.4.4 (Claim Billing or Encounter) – an incorrect Field ID is listed in the Situation column of the Originally Prescribed Product/Service ID Qualifier (453-EJ). The correct Field ID is 445-EA.

Added September 2026

2.2 Batch Standard Version 15©

- The field File Type was incorrectly labeled as field ID 702 instead of 702-MC. Any instance of File Type (702) should be File Type (702-MC).

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3. EDITORIAL SECTION

3.1 Transmission Level Segments

Question: Do any segments other than the respective headers belong to the transmission level, not the transaction level? If all segments other than the respective headers belong to the transaction level, how should Section 25 be understood? How do statements like that found in 22.5.4 which state there are "no situational transaction-level segments" be applied?

Answer: In the Implementation Guide, discussion of transmission level and transaction level has no significant meaning to how transactions are structured, and any actual or perceived contradictions can be effectively ignored.

Added May 2024

3.2 Order of Fields in a Segment

Question: Most of the time Mandatory fields are presented at the beginning of the segment within the Implementation Guide segment charts and in the F6 Matrices, but there are several examples where Mandatory fields are listed after other Situational fields in request or response segment charts. Is it correct to interpret that these Mandatory (M) fields are expected to be sent prior to any Required (R), Situational (Q), Optional (O), or Informational (I) fields within the segment as used within a specific transaction?

Answer: Yes, Mandatory fields are expected to be reported before any Situational (Q), Optional (O), or Informational (I) fields. Refer to "Section 5.1.2.1 – Segments" in the Telecommunication Standard Implementation Guide Version F6©.

In general, the Telecommunication Implementation Guide vF6© segment charts and matrices display Mandatory (M) fields before non-mandatory fields within the segment. There are however, several Mandatory (M) fields displayed after non-mandatory fields. This is a display issue only. The following lists the affected segments with Mandatory fields displayed after Required (R), Situational (S), Optional (O), or Informational (I) fields and provides the expected order of Mandatory (M) fields for each segment.

Compound Segment:

- Compound Ingredient Component Count (447-EC), Compound Product ID Qualifier (488-RE), Compound Product ID (489-TE), Compound Ingredient Quantity (448-ED) are Mandatory that are expected to be sent after all previous Mandatory (M) fields in the segment (versus after Situational (Q) fields in the segment as currently displayed in the vF6 Implementation Guide).
- All fields within the Compound Ingredient field grouping, regardless of their Situational (Q) status, would follow the logical grouping field order.
- Based on the rules for the ordering of Mandatory (M) fields as well as requirements for the logical grouping of sets of fields, the fields in the Compound segment would be ordered as follows (note: the qualified fields would only be sent when applicable):

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Field			Field Name	Mandatory or Situational
111-AM	Segment Identification			M
450-EF	Compound Dosage Form Description Code			M
451-EG	Compound Dispensing Unit Form Indicator			M
447-EC	Compound Ingredient Component Count			M
	488-RE	Compound Product ID Qualifier		M***R***
	489-TE	Compound Product ID		M***R***
	448-ED	Compound Ingredient Quantity		M***R***
	449-EE	Compound Ingredient Drug Cost		Q***R***
	490-UE	Compound Ingredient Basis of Cost Determination		Q***R***
	362-2G	Compound Ingredient Modifier Code Count		Q
		363-2H	Compound Ingredient Modifier Code	Q***R***
C60-AG	Compound Level of Complexity			Q

Note: Payers should not reject claims where the Mandatory (M) fields may be submitted out of order.

Response Status Segment:

- Help Desk Support Type Count (C72-BH) and Help Desk Support Type (C71-BG) are Mandatory (M) fields that are expected to be sent after all previous Mandatory (M) fields in the segment (versus after Situational (Q) fields in the segment as currently displayed in the vF6 Implementation Guide).
- All fields within the Help Desk field grouping, regardless of their Situational (Q) status, would follow the logical grouping field order.
- Based on the rules for the ordering of Mandatory (M) fields as well as requirements for the logical grouping of sets of fields, the following fields must be sent at the start of the Response Status Segment (note: the qualified fields would only be sent when applicable).

Field			Field Name	Mandatory or Situational
111-AM	Segment Identification			M
112-AN	Transaction Response Status			M
C72-BH	Help Desk Support Type Count			M
	C71-BG	Help Desk Support Type		M***R***
	C67-BB	Help Desk Business Unit Type Count		R
		C66-BA	Help Desk Business Unit Type	Q***R***
		C70-BF	Help Desk Contact Information Qualifier	Q***R***
		C68-BC	Help Desk Contact Information	Q***R***
		C69-BD	Help Desk Contact Information Extension	Q***R***
Any remaining Response Status segment fields applicable to the response can be returned after this.				

Response Intermediary Segment:

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- Intermediary Help Desk Support Type Count (C86-KC), and Intermediary Help Desk Support Type (C85-KB) are Mandatory (M) fields that are expected to be sent after all previous Mandatory (M) fields in the segment (versus after Situational (Q) fields in the segment as currently displayed in the vF6 Implementation Guide).
- All fields within the Intermediary Help Desk field grouping, regardless of their Situational (Q) status, would follow the logical grouping field order.
- Based on the rules for the ordering of Mandatory (M) fields as well as requirements for the logical grouping of sets of fields, the fields of the Response Intermediary Segment would be ordered as follows (note: the qualified fields would only be sent when applicable):

Field			Field Name	Mandatory or Situational
111-AM	Segment Identification			M
C86-KC	Intermediary Help Desk Support Type Count			M
	C85-KB	Intermediary Help Desk Support Type		M***R***
	C81-G9	Intermediary Help Desk Business Unit Type Count		R
		C80-G8	Intermediary Help Desk Business Unit Type	Q***R***
		C84-KA	Intermediary Help Desk Contact Information Qualifier	Q***R***
		C82-JP	Intermediary Help Desk Contact Information	Q***R***
		C83-JR	Intermediary Help Desk Contact Information Extension	Q***R***
B52-8R	Response Intermediary Authorization Count			Q
	B53-8S	Response Intermediary Authorization Type ID		Q***R***
	B54-8T	Response Intermediary Authorization ID		Q***R***
	B51-8Q	Intermediary Message		Q***R***

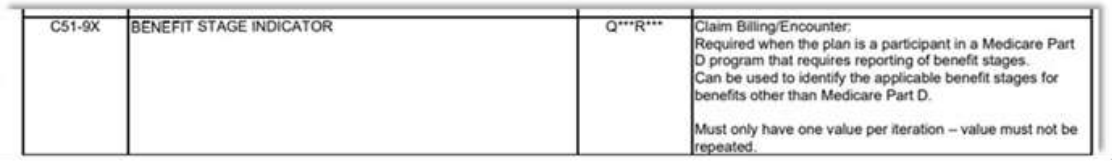
Added August 2024

3.3 ECL Values

Question: Can the same ECL value associated to a single field be sent multiple times within a distinct iteration of the field grouping for a single request or response transaction?

Answer: As of the Telecommunication Standard Implementation Guide vF6©, there is documentation in place for two specific fields that states the same ECL value cannot be repeated.

1. Benefit Stage Indicator (C51-9X)
   a. Telecommunication Standard Segment Diagrams, Situation of Use states *"Must only have one value per iteration, value must not be repeated"*



C51-9X	BENEFIT STAGE INDICATOR	Q***R***	Claim Billing/Encounter: Required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stages. Can be used to identify the applicable benefit stages for benefits other than Medicare Part D. Must only have one value per iteration – value must not be repeated.

2. Additional Message Information Qualifier (132-UH)
   a. Data Dictionary© description states *"Each value may only occur once per transaction…"*

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Additional Message Information Qualifier

132-UH

Format qualifier of the Additional Message Information (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., 0-9, A-Z).

After a comprehensive review, it was determined there are additional fields where the same value should not repeat within a distinct iteration of the field grouping for a single request or response transaction. The below table lists the Count/Counter fields and the associated Max count within the Telecommunication Standard vF6©. The associated fields with ECL values within the field grouping are also listed. The recommendation as to whether the same ECL value can repeat or not repeat is listed in the last column to the right.

Telecommunication Standard Implementation Guide vF6© Count/Counter Field Max Counts and Associated Repeating Fields with ECL Values

Request or Response Transaction	Count /Counter Field	Max Count	Repeating Field ID	Repeating Field Name	Can the same ECL value repeat?
Request	Clinical Information Counter (493-XE)	5	496-H2 497-H3	Measurement Dimension Measurement Unit	Yes
Request	DUR/PPS Code Counter (473-7E)	9	439-E4 440-E5 441-E6 474-8E 475-J9 476-H6	Reason For Service Code Professional Service Code Result of Service Code DUR/PPS Level of Effort DUR/DUE Co-Agent ID Qualifier DUR/DUE Co-Agent ID	Yes
Request	Procedure Modifier Code Count (458-SE)	10	459-ER	Procedure Modifier Code	Yes
Request	Submission Clarification Code Count (354-NX)	5	420-DK	Submission Clarification Code	No
Request	Submission Type Code Count (D16-KZ)	5	D17-K8	Submission Type Code	No
Request	Patient ID Count (618-RR)	9	331-CX	Patient ID Qualifier	Yes
Request	Diagnosis Code Count (491-VE)	5	424-DO	Diagnosis Code	No
Request	Compound Ingredient Component Count (447-EC)	25	488-RE 490-UE	Compound Product ID Qualifier Compound Ingredient BOC	Yes

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Request or Response Transaction	Count /Counter Field	Max Count	Repeating Field ID	Repeating Field Name	Can the same ECL value repeat?
Request	Compound Ingredient Modifier Code Count (362-2G)	10	363-2H	Compound Ingredient Modifier Code	Yes
Request	Other Amount Claimed Submitted Count (478-H7)	3	479-H8	Other Amount Claimed Submitted Qualifier	No
Request	Regulatory Fee Count (D60-RK)	3	D61-RL	D61-RL Regulatory Fee Type Code	Yes
Request	Coordination of Benefits/Other Payments Count (337-4C)	3	338-5C 339-6C C47-9T	338-5C Other Payer Coverage Type* 339-6C Other Payer ID Qualifier C47-9T Other Payer Adjudicated Program Type	*Other Payer Coverage Type (338-5C) should not repeat for the request. 339-6C and C47-9T can repeat.
Request	Other Payer Reject Count (471-5E)	5	472-6E	Other Payer Reject Code	Yes
Request	Other Payer Amount Paid Count (341-HB)	9	342-HC	Other Payer Amount Paid Qualifier	No
Request	Other Payer-Patient Responsibility Amount Count (353-NR) *Note the occurrences are dependent upon the number of component parts returned from a previous payer.*	25	351-NP	Other Payer-Patient Responsibility Amount Qualifier	No
Request	Benefit Stage Indicator Count (C50-9W)	4	C51-9X	Benefit Stage Indicator	No
Request	Other Payer Regulatory Fee Type Count (D53-P9)	3	D63-RN D52-P8	Other Payer Regulatory Fee Type Code Other Payer Regulatory Fee Exempt Indicator	Yes
Request	Intermediary ID Count (B44-8G)	5	B45-8H B46-8J B47-8K B49-8N B55-8U	Intermediary ID Type Code Intermediary ID Type Entity Intermediary ID Qualifier Intermediary ID State/Province Address Intermediary ID Country Code	Yes

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Request or Response Transaction	Count /Counter Field	Max Count	Repeating Field ID	Repeating Field Name	Can the same ECL value repeat?
Response	DUR/PPS Response Code Counter (567-J6)	9	439-E4 528-FS 475-J9 529-FT E95-Z9 E94-ZA 532-FW 533-FX F01-Z4 F05-Z0 F07-YL F09-YI	Reason for Service Code Clinical Significance Code DUR/DUE Co-Agent ID Qualifier Other Pharmacy Indicator Other Pharmacy ID Qualifier Unit of Measure for Previous Disp Qty Database Indicator Other Prescriber Indicator Other Prescriber ID Qualifier DUR/DUE Compound Product ID Qualifier DUR/DUE Maximum Daily Dose UoM DUR/DUE Minimum Daily Dose UoM	Yes
Response	Reject Count (510-FA)	5	511-FB	Reject Code	A reject code may be repeated if a field repeats (e.g., ingredients in a compound). The Reject Field Occurrence Indicator (546-4F) field should be used to identify the specific repeating field associated to the reject code. Reject Field Occurrence Indicator (546-4F) - Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.
Response	Approved Message Code Count (547-5F)	5	548-6F	Approved Message Code	No
Response	Additional Message Information Count (130-UF)	25	132-UH	Additional Message Information Qualifier	No

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Request or Response Transaction	Count /Counter Field	Max Count	Repeating Field ID	Repeating Field Name	Can the same ECL value repeat?
Response	Formulary Alternative Product Count (551-9F)	6	D42-PV D43-PZ 552-AP	Formulary Alternative Plan Benefit Tier Formulary Alternative Reason Code Formulary Alternative ID Qualifier	Yes
Response	Formulary Alternative Required Therapy Indicator Count (D44-P0)	6	D45-P1 D46-P2	Formulary Alternative Req Therapy Indicator Formulary Alternative Required Therapy Time Period Qualifier	Yes
Response	Help Desk Support Type Count (C72-BH)	5	C71-BG	Help Desk Support Type	Yes
Response	Help Desk Business Unit Type Count (C67-BB)	5	C66-BA C70-BF	Help Desk Business Unit Type Help Desk Contact Information Qualifier	Yes
Response	Payer/Health Plan ID Count (C96-KR)	3	568-J7	Payer/Health Plan ID Qualifier	Yes
Response	Patient Pay Component Count (C94-KP)	25	C95-KQ	Patient Pay Component Qualifier	No
Response	Regulatory Fee Count (D60-RK)	3	D61-RL D62-RM	Regulatory Fee Type Code Regulatory Fee Exempt Indicator	Yes
Response	Other Amount Paid Count (563-J2)	9	564-J3	Other Amount Paid Qualifier	No
Response	Other Benefit Count (D26-M8)	9	D40-PN	Other Benefit Type Code	No
Response	Other Benefit Detail Information Count (D37-N8)	9	D32-MS	Other Benefit Detail Information Indicator	No
Response	Other Payer ID Count (355-NT) *Maximum count of 4 for claim, service and prior authorization response transactions. Maximum count of 9 for eligibility response transactions.*	4, 9	338-5C D41-PQ D50-P6 C47-9T 339-6C 143-UW	Other Payer Coverage Type Other Payer Relationship Type Other Payer Benefit Classification Other Payer Adjudicated Program Type Other Payer ID Qualifier Other Payer Patient Relationship Code	Yes
Response	Benefit Stage Indicator Count (C50-9W)	4	C51-9X	Benefit Stage Indicator	No
Response	Benefit Type Opportunity Count (C59-AF)	9	C58-AE	Benefit Type Opportunity	No
Response	Patient ID Count (618-RR)	9	331-CX	Patient ID Qualifier	Yes
Response	Intermediary ID Count (B44-8G)	5	B53-8S	Response Intermediary Auth Type ID	Yes
Response	Intermediary Help Desk Support Type Count (C86-KC)	5	C85-KB	Intermediary Help Desk Support Type	Yes

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Request or Response Transaction	Count /Counter Field	Max Count	Repeating Field ID	Repeating Field Name	Can the same ECL value repeat?
Response	Intermediary Help Desk Business Unit Type Count (C81-G9)	5	C80-G8 C84-KA	Intermediary Help Desk Business Unit Type Intermediary Help Desk Contact Info Qual	Yes

Added November 2024

3.4 Request Transaction Header Segment

3.4.1 Transaction Count

Question: "As of Version E7, a transmission contains only one request transaction. The processor/PBM must respond to each request. The Transaction Count in the response must match the Transaction Count in the request. The Response Status Segment will have response information for each request transaction. Each transaction response will contain its own Transaction Response Status." Refer to Section 26.2 of the Telecommunication Standard Version F6© document.

Understanding that many errors at the syntactical level will have been made/encountered in order to participate in such an exchange, what is the proper response to a Version E7 or above transmission that has a Transaction Count greater than 1?

Answer: The Header Response Status (501-F1) and the Transaction Response Status (112-AN) must contain the value of "R". Use Reject Code of A9 – Missing/Invalid Transaction Count in the Reject Code (511-FB). The Transaction Count (109-A9) must be "1".

Added November 2023

3.5 Request Patient Segment (01)

3.5.1 Place of Service (307-C7)

Question: How is the Place of Service (307-C7) field used in Telecommunication VF6 B1 claim requests since the field definition and situations of use have changed from VD.0?

Answer: The changes to the NCPDP Place of Service (307-C7) field for VF6 were made to align with the CMS use of Place of Service within professional claims to specify where service(s) were rendered. The changes effective with VF6 may impact when the Place of Service (307-C7) field may be applicable to a B1 claim billing request based on how payers are using this field in VD.0 claims. NCPDP recommends the Place of Service (307-C7) field not be required in B1 claim requests for drug product billing only, as the dispensing service will always be from the pharmacy place of service.
Summary of Changes:

- VD.0 Place of Service 307-C7 field
  - Definition: Code identifying the place where a drug or service is dispensed or administered.
  - Claim Billing Situation: (Q) Required if this field could result in different coverage, pricing, or patient financial responsibility.
- VF6 Place of Service (307-C7) field (Refer to DERF 1414)
  - Definition: Code identifying the place where a product or service is administered.

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  - Claim Billing Situation: (Q) Required if necessary for state/federal/regulatory agency programs. Otherwise, required when necessary to identify the Place of Service for non-self-administered drugs
- CMS Place of Service Code List Description
  - Place of Service Code value 01 – Pharmacy retains the original description of: A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (Effective October 1, 2003) (Revised, effective October 01, 2005)

B1 Claim Billing:

- The place of service associated with B1 claim billing will generally be the pharmacy as this is where the service of dispensing a product occurs.
- A place of service other than pharmacy may be associated with B1 claim billing, when both a dispensing and administration service for a non-self-administered drug are billed, and the administration occurred outside the pharmacy.
- For VF6 B1 claims:
  - NCPDP recommends the Place of Service (307-C7) field not be required in B1 claim requests for drug product billing only, as the dispensing service will always be from the pharmacy place of service.
  - Place of Service (307-C7) field may be requested on B1 claim requests for a non-self-administered drug plus the administration service, as the location of the administration service could result in different coverage, pricing, or patient financial responsibility associated with the B1 claim response.
  - Place of Service (307-C7) field is not recommended in B1 claims in an LTPAC setting, regardless of the drug product. It is not always known by the LTC pharmacy where the product is ultimately administered. PBM / Payers can identify an LTC pharmacy using ECL value 5 in the Pharmacy Service Type (147-U7) field. It is recommended PBM/Payers not reject claims that are not populated with Place of Service from an LTPAC setting.

Added September 2026

3.6 Request Insurance Segment (04)

3.7 Request Claim Segment (07)

3.7.1 Days Supply (405-D5)

Question: How do you set the days supply for a recurring medication that has a long period between dosing or administering (such as once every 120 days, 180 days, etc…) that is dispensed as a single dose? How do you keep a long days supply from causing a misrepresentation of the claim as mail order?

Answer: The actual days supply (in this case days between dosing) is to be sent in order to properly apply DUR edits. The pharmacy system vendor and the processor must be able to support 3 digits in the Days Supply as the standard supports 3 digits. Days Supply should not be used as a determination for the type of pharmacy setting. Pharmacy Service Type (147-U7) is used for identifying the type of pharmacy submitting the claim.

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3.7.2 Long Term and Post Acute Care (LTPAC) Qualified Environment

Three new fields were added to address the claim requirements in the Long Term and Post Acute Care (LTPAC) qualified environment. The LTPAC Billing Methodology (C90-KH) field was created to identify the type of billing that the date of service represents. The Number of LTPAC Dispensing Events (C92-KM) field was created to indicate the count of dispensing events that comprise the claim for the days supply being submitted. The LTPAC Dispense Frequency (C91-KK) field was created to identify the typical interval pattern of a dispensing or resupply by the LTC pharmacy.

LTPAC Billing Methodology (C90-KH)

LTPAC Billing Methodology (C90-KH) in the claim segment indicates the billing methodology used for the claim submission. Below are example billing methodologies. Refer to the ECL for current values.

Billing full quantity as dispensed on date of dispensing.

- The quantity and days supply of product or service on the claim have been provided in full on the date of service stated on the claim.

Post- consumption billing

- Popular in the LTPAC Qualified setting, this refers to the practice of aggregating quantities of dispensed product or service that occurs over some period of elapsed days. One or more dispensings occurred over those days, most typically within a monthly period. The date of service on the claim represents either the billing date or the first date that the product or service was dispensed during the days supply for the entire claim.

Pre-consumption billing

- This refers to the practice of billing for a claim using a date of service that is the first date of one or more dispensings, but the subsequent dispensings of product or service that make up the full claim may not have yet occurred.

Number Of LTPAC Dispensing Events (C92-KM)

Number of LTPAC Dispensing Events (C92-KM) in the claim segment provides the total number of pharmacy dispensings to help trading partner agreements be more straightforward to administer. The field will indicate the count of dispensing events that comprise the claim for the days supply being submitted.

For example, if a 26-day supply claim consists of three 7-day resupplies and one 5-day initial fill then the Number of LTPAC Dispensing Events (C92-KM) is four. If the medication is dispensed using in-facility technology that is managed via pharmacy system integration and the medication is given three times daily for a 30-day supply, then the Number of LTPAC Dispensing Events (C92-KM) is 90.

The value should be assessed in context with the value of the LTPAC Billing Methodology (C90-KH) and Special Package Indicator (429-DT).

LTPAC Dispense Frequency (C91-KK)

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LTPAC Dispense Frequency (C91-KK) in the claim segment represents the dispensing frequency which refers to the *typical interval pattern* of dispensing or resupply by the pharmacy that occurred for the claim being submitted. Refer to the ECL for current values.

For example, if a claim is submitted for a 30-day supply and the dispensing occurred as 2 initial days, followed by four 7-day resupplies, then the pharmacy is going to be indicating that the resident is being dispensed on a 7-day dispensing interval resupply pattern (or cycle).

Reject Code (511-FB) values appropriate for LTC Short Cycle:
Below are the reject codes related to LTC Short Cycle and examples of when the values should be used.

Value	Description	Use Cases
597	LTC Dispensing Type Does Not Support The Packaging Type	Value is N on the Validity Matrix*
613	The Packaging Methodology Or Dispensing Frequency Is Missing Or Inappropriate For LTC Short Cycle	SCC 16, 21 or 36 is submitted with LTPAC Dispense Frequency values 2-15
DF4	Invalid LTPAC Dispense Frequency and Submission Clarification Code (SCC) Combination	Value is N on the SCC and Dispense Frequency Combo Spreadsheet*

*Documents are located on the WG14 Member Home Page

SPLIT BILLING IN LONG TERM CARE
Below is an update to Section 28.6.3 Split Billing in Long Term Care of the Telecommunication F6 Implementation Guide to provide clarification related to the dispensing fee. The reference to MDS and RUGS score has also been removed in favor of more general terminology.

A skilled nursing facility is reimbursed for Medicare Part A based on a per-diem reimbursement system that focuses on time-and-motion of a nurse's attention to the resident. The medications that a patient receives during that stay are also paid for using the same Medicare Part A funds. Part A reimbursement ceases as of the Part A benefit expiration date for the resident. When applicable, the next covering business entity (insurance, PDP, family, estate) is billed for the rest of the medication days supply.

> Scenario: A Medicare Part A resident is dispensed a 30 day supply of medications on September 6th. Eleven days into that 30-day supply, the resident's Part A benefit no longer applies. Rather than return the unused medications to the pharmacy, and then redispense a fresh supply to the resident, the resident keeps the medication. After reversing the original 30 day claim, the 11 days supply is billed to the Part A stay. The 19 days supply is then billed to the next payer using a Date of Service (401-D1) of September 17th for a 19 days supply of ingredient cost and no dispensing fee.

The scenario mentions that no dispensing fee should be submitted. The recommendation is the submitted amount of the dispensing fee for the second days supply interval of a split bill must = "$0.00". If a non-zero dispensing fee is submitted by the pharmacy and accepted by the payer, the payer should return a Dispensing Fee Paid (507-F7) amount of $0.00.

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Added May 2024

3.7.3 Route of Administration (995-E2) and SNOMED CT Codes

Telecommunication Standard Version D.0© and above uses the Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) terminology for the Route of Administration (995-E2). NCPDP's External Code List© (ECL) entry for Route of Administration (995-E2) points to National Library of Medicine (NLM)'s Value Set Authority Center (VSAC) for the list of values and includes a link with download instructions, which can be found here. To ensure consistent values and processes across trading partners, NCPDP recommends using the downloadable list of codes published biannually by NLM.

Please see "*Appendix B. Route of Administration Questions*" for specific FAQs on Route of Administration (995-E2) and SNOMED CT values.

Updated June 2026

3.7.4 Submission Clarification Code (SCC)

The SCC is a code indicating the pharmacy is clarifying the claim submission or resubmission. For example, it provides additional clarification as to why the transaction is being submitted where under normal circumstances the claim may not be covered. The SCC may be submitted proactively to prevent or reactively to override a reject.

Question: Does Submission Clarification Code (420-DK) value 49 – Prescriber does not currently have an active Type 1 NPI – imply that the prescriber's Medicare Part D or Medicaid prescriber enrollment status has been validated?

Answer: No, SCC value of 49 does not imply Medicare Part D or Medicaid prescriber enrollment has been validated. SCC value of 49 is used to indicate the prescriber does not have an Active Type 1 NPI.

> ***Sub-question 1:*** *Which SCC value is used to communicate the prescriber is enrolled with a specific Medicaid plan, when the payer/processor rejects the claim indicating the prescriber is not enrolled?*
>
> ***Sub-answer 1:*** *SCC 55 - Prescriber Enrollment in State Medicaid Program has been validated – is the appropriate SCC to use to communicate the prescriber is enrolled with the specific Medicaid plan, as may occur with rare data file timing issues. SCC 55 is not used as an emergency override for unenrolled prescribers.*
>
> ***Sub-question 2:*** *Which SCC value is used to communicate the prescriber is enrolled with the Medicare Part D program?*
>
> ***Sub-answer 2:*** *No SCC value is appropriate because there is currently no prescriber enrollment requirement for Medicare Part D. CMS Rule 4182-F replaced the Medicare Prescriber Enrollment requirement under CMS 4159 and IFC 6107 with the Medicare Precluded Provider requirement.*
>
> *Added June 2026*

3.7.5 Total Prescribed Quantity Remaining

Question: What is the purpose of the Total Prescribed Quantity Remaining Field (D02-KW) that was created for use in F6?

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Answer: The Total Prescribed Quantity Remaining (D02-KW) field was added to the Telecommunication Standard VF6© to support scenarios involving multiple fills either for Schedule 2 drugs where the Quantity Dispensed (442-E7) is less than the Quantity Prescribed (460-ET) or for Schedule 3-5 drugs where the Quantity Dispensed (442-E7) could be the same or less than the Quantity Prescribed (460-ET) across the refills allowed, since each fill could be submitted to different processors or dispensed as cash pay. This field allows the pharmacy dispensing the medication to provide a complete picture of the quantity still available to be dispensed to the patient on subsequent fills of the prescription. This field is used to provide additional information to the receiving entity.

Added September 2026

3.8 Request Pharmacy Provider Segment (02)

3.9 Request Prescriber Segment (03)

3.9.1 No Prescriber Prescription

Question: What should be submitted on a Version D.0 claim to indicate the claim is not associated with a patient specific prescription/standing order (i.e., there is no prescriber)? What should be submitted on a Version F6 claim?

Answer: To support recent regulatory changes that support coverage for products without a prescription, updates were made to the External Code List© (ECL) to distinctly identify a claim is not associated with a patient specific prescription/standing order. The ECL changes were effective in the October 2025 Annual ECL implementation.

- As of October 2025:
  - Prescriber ID Qualifier (466-EZ) value 18 (No Prescriber ID, No Prescription Associated to the transaction.) will be available for use within Version D.0 and Version F6 transactions (if applicable).
  - Prescriber ID (411-DB) = 0 (as directed by the Prescriber ID Qualifier (466-EZ) value 18 limitation).
  - Prescription Origin Code (419-DJ) value 6 (No Associated Prescription) will be available for use within Version D.0 and Version F6 transactions (if applicable).

When the above values are submitted and the payer determines a prescription is required, the claim should reject with new Reject Code (511-FB) DO6 - Prescription Required. Claim without an associated prescription is not covered.

Updated June 2026

3.9.2 Prescriber DEA Number (D01-KV)

Question: How should pharmacies populate/submit the VF6 **Prescriber DEA Number (D01-KV)** field when a controlled substance prescription includes a hospital or institutional DEA with a suffix (e.g., AB1234567-119933)?

Answer: Pharmacies should submit **only the 9-character DEA number** (two letters followed by seven digits) in the Prescriber DEA Number (D01-KV) field. **DEA suffixes should not be submitted**, even if they appear on the prescription.

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Example: If the prescription contains AB1234567-119933, pharmacies should only submit the 9-character DEA: 'AB1234567'. The suffix '119933' should not be submitted as part of the claim.

DEA suffixes are not maintained by an authoritative source and there is no standardized mechanism to validate them in electronic transactions. Payer/processor validation is based upon the first 9 characters of the DEA number.

The Prescriber DEA Number (D01-KV) is intended for controlled substance prescriptions only and should not be submitted for non-controlled substances.

Added June 2026

Question: When submitting the Prescriber DEA Number (D01-KV) for a controlled substance, is the pharmacy required to submit the Prescriber ID (411-DB) field?

Answer: Yes. When submitting the Prescriber DEA Number (D01-KV) for a controlled substance, pharmacies must also submit the Prescriber ID (411-DB) field with the appropriate Prescriber ID Qualifier (466-EZ).

Added September 2026

3.9.3 Prescriber ID Rejections

Question: If the practitioner who signed the prescription (i.e. prescriber) does not meet the payer's prescriber enrollment requirements and state law requires a supervising or attending physician be associated to the prescriber, can the supervising or attending physician's ID be submitted as the Prescriber ID (411-DB)?

Answer: No. The Prescriber ID (411-DB) submitted must represent the practitioner who signed the prescription and correlate to the below additional prescriber data elements, when submitted.

- Prescriber Last Name (427-DR)
- Prescriber First Name (364-2J)
- Prescriber Telephone Number (498-PM)
- Prescriber Street Address Line 1 (B27-7U)
- Prescriber Street Address Line 2 (B28-7V)
- Prescriber City Address (366-2M)
- Prescriber State/Provence Address (367-2N)
- Prescriber ZIP/Postal Code (368-2P)

As a result of a POS denial for prescriber enrollment, a new prescription may be required from a covered prescriber. This would also apply to other prescriber types where a supervising physician or a Collaborative Practice Agreement applies per state law. The Prescriber ID (411-DB) would be represented as defined below.

- The practitioner with prescriptive authority per state regulations not requiring a supervising physician is prescribing and signing the prescription for the medication/service for which they are authorized.
    - Prescriber ID (411-DB) – contains the *practitioner with prescriptive authority* who is prescribing and signing the prescription for the medication/service

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- The resident where state law may require a supervising physician is prescribing and signing the prescription for the medication/service for which they are authorized.
    - Prescriber ID (411-DB) – contains the *resident* who is prescribing and signing the prescription for the medication/service
- The nurse practitioner/physician assistant is prescribing and signing the prescription for the medication/service for which they are authorized.
    - Prescriber ID (411-DB) – contains the *nurse practitioner/physician assistant* who is prescribing and signing the prescription for the medication/service
- The physician and nurse practitioner/physician assistant have a Collaborative Practice Agreement. The nurse practitioner/physician assistant is prescribing and signing the prescription for the medication/service for which they are authorized. A physician is supervising the nurse practitioner/physician assistant (direct or indirect).
    - Prescriber ID (411-DB) – contains the *nurse practitioner/physician assistant* who is prescribing and signing the prescription for the medication/service
- The pharmacist is allowed to prescribe without a Collaborative Practice Agreement. The pharmacist is prescribing and signing the prescription for the medication/service for which they are authorized.
    - Prescriber ID (411-DB) – contains the *pharmacist* who is prescribing and signing the prescription for the medication/service
- The physician and pharmacist have a Collaborative Practice Agreement. The pharmacist is prescribing and signing the prescription for a medication/service for which they are authorized.
    - Prescriber ID (411-DB) – contains the *pharmacist* who is prescribing and signing the prescription for the medication/service
- When a pharmacist administers the medication/service which requires a prescription/prescription order/protocol per state law (such as vaccines)
    - Prescriber ID (411-DB) – contains the ID of the clinician who signed the prescription/prescription order/protocol for the medication/service. See 1-6 above.
    - Provider ID (444-E9) - could contain the pharmacist who is *administering* a vaccine/service.
- When a pharmacist dispenses a federal legend, OTC or Additional Condition for Non-Prescription Use (ACNU) product under a Standing Order[1]
    - Prescriber ID (411-DB) contains the ID of the clinician who signed the Standing Order for the specified product/product category

Added September 2026

[1] In this section the term "standing order" means a document prepared by a person authorized to prescribe medication that permits another person to acquire, dispense or administer medication without a person-specific prescription. (https://www.law.cornell.edu/uscode/text/42/290ee#g)

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Question: When should Reject Code 56 "Non-Matched Prescriber ID" be used?

Answer: Reject code 56 should only be used when the ID submitted is not found within the processor's prescriber data file given:

- The submitted ID meets the applicable formatting/check digit for the submitted Prescriber ID qualifier (466-EZ) **and**
- A distinct reject code is not available to describe the unmatched or non-covered situation.

When reject code 56 is returned, the processor should reference within the Additional Message field (526- FQ) the specific non-matched condition.

Reject Code 56 should not be used when the submitted ID is found; however, additional prescriber validation rules are not able to locate associated prescriber IDs. For example, when the submitted NPI is found and the processor is not able to locate the prescriber's DEA number, the processor should return the applicable prescriber DEA reject code (values 43-46).

Added September 2026

Question: There are various provider exclusion files maintained by government entities, such as OIG excluded providers, Medicaid exclusions, CMS preclusions. Can Reject Code A1 be used regardless of which exclusion file contains the submitted Provider/Prescriber ID, and can the data source that triggered a prescriber validation reject be identified in the response?

Answer: Reject code A1 (ID Submitted Is Associated With An Excluded Prescriber) should be used when a provider is found to be excluded as listed on any of the government-maintained files (see below), except when the provider is found to be a CMS Precluded Provider. In a CMS Precluded Provider situation (provider is listed on the Precluded Provider file), reject code 929 (ID Submitted is Associated to a Precluded Prescriber) should be returned.

For prescription claims billed to a government program, the following files maintained by government entities, are used to validate provider exclusion status. When the provider is determined to be excluded as of the claim date of service, then either reject code A1 and/or 929 would be returned. If a provider is listed on any of the files as an active exclusion, treat the provider as excluded and return the following reject code:

- Use Reject Code (511-FB) value A1 (ID Submitted Is Associated With An Excluded Prescriber)
  - OIG List of Excluded Individuals and Entities (LEIE)
  - GSA (General Service Administration)/SAM (System for Award Management)
  - Medicaid State Exclusion File
- Use Reject code (511-FB) value 929 (ID Submitted is Associated to a Precluded Prescriber)

Depending on the processor's rules, one or both reject codes may be returned when the provider appears on the CMS Precluded Provider file as well as one of the other files.

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To provide additional information regarding the exclusion, it is recommended the specific file in which the exclusion was determined be referenced in the appropriate claim response field. For the Telecommunication Standard Version D.0©, the Additional Message Information field (526-FQ) can be used to identify the data source that triggered the prescriber validation conflict.

The information should be returned with the below Additional Message Information Qualifiers (132-UH):

- 26 – INVALID PROVIDER DATA SOURCE
- 27 – INVALID PROVIDER DATA SOURCE STATE CODE

The information will be available as distinct response fields in the Telecommunication Standard Version F6© (E87-ZV: Data Source of Invalid Provider Determination and E88-ZZ: State Code for Data Source of Invalid Provider Determination).

Please refer to the below chart for guidance on the specific values to return in the Additional Message Information field (526-FQ) for each of these qualifiers and the associated reject codes for the specific prescriber validation error.

Prescriber Validation Error	**Reject Code (511-FB)**	**Additional Message Information Qualifier(s) (132-UH)**	**Additional Message Information (526-FQ)**	**Description of Invalid Provider Data Source**
Prescriber has been identified as an Excluded Prescriber via the OIG LEIE file	A1 ID Submitted is associated with an Excluded Prescriber	26 - INVALID PROVIDER DATA SOURCE	**"OIG LEIE"**	"Office of Inspector General List of Excluded Individuals/Entities": List of all currently excluded individuals and entities as determined by OIG authority to exclude individuals and entities from Federally funded health care programs pursuant to section 1128 of the Social Security Act (Act) (and from Medicare and State health care programs under section 1156 of the Act).
Prescriber has been identified as an Excluded Prescriber via the SAM file	A1 ID Submitted is associated with an Excluded Prescriber	26 - INVALID PROVIDER DATA SOURCE	**"SAM"**	"System for Award Management": The SAM Exclusions extract contains a list of all currently active exclusions in SAM. These include exclusions for Individuals, Firms, Special Entity Designations and Vessels. https://www.sam.gov/SAM/pages/public/index.jsf

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Prescriber Validation Error	Reject Code (511-FB)	Additional Message Information Qualifier(s) (132-UH)	Additional Message Information (526-FQ)	Description of Invalid Provider Data Source
				Note: SAM replaces General Services Administration (GSA) data source.
Prescriber has been identified as a Terminated/Excluded Medicaid Prescriber	A1 ID Submitted is associated with an Excluded Prescriber	26 - INVALID PROVIDER DATA SOURCE & 27 – INVALID PROVIDER DATA SOURCE STATE CODE	**"STATE MEDICAID EXCLUSION/TERMINATION"** **&** **2-character State Code of the applicable State Medicaid Exclusion file. Refer to state abbreviations within the ECL SHARED CODE LIST: State/Province Address**	State issued list of providers excluded/terminated from participation in the State Medicaid program.
Prescriber/Provider has been identified as not enrolled with the State Medicaid program	889 Prescriber Not Enrolled in State Medicaid Program 890 Pharmacy Not Enrolled in State Medicaid Program	26 - INVALID PROVIDER DATA SOURCE & 27 – INVALID PROVIDER DATA SOURCE STATE CODE	**"STATE MEDICAID ENROLLMENT"** **&** **2-character State Code of the applicable State Medicaid Enrollment file. Refer to state abbreviations within the ECL SHARED CODE LIST: State/Province Address**	State issued list of providers' enrollment status within the State Medicaid program. State Medicaid provider enrollment data aligns to CMS Medicaid and other federal provider screening requirements

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Prescriber Validation Error	Reject Code (511-FB)	Additional Message Information Qualifier(s) (132-UH)	Additional Message Information (526-FQ)	Description of Invalid Provider Data Source
Prescriber has been identified as a Precluded Prescriber	929 ID Submitted Is Associated With A Precluded Prescriber 930 ID Submitted Is Associated To A Precluded Pharmacy	26 - INVALID PROVIDER DATA SOURCE	**"CMS PRECLUSION LIST"**	"Centers for Medicare and Medicaid Services" Preclusion List: A list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
Prescriber's NPI has been identified as inactive or not found	42 Plan's Prescriber database indicates the Prescriber ID Submitted is inactive or expired. 826 Prescriber NPI Submitted Not Found Within Processor's NPI File	26 - INVALID PROVIDER DATA SOURCE	**"NPPES NPI"**	"National Plan and Provider Enumeration System - National Provider Identifier": NPPES assigns standard unique identifiers (NPI) for health care providers and health plans. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice.
Prescriber's DEA has been identified as inactive, not found, or not registered with the applicable drug schedule	43 Plan's Prescriber database indicates the Prescriber DEA Number is inactive or expired	26 - INVALID PROVIDER DATA SOURCE	**"NTIS DEA"**	"National Technical Information Service - Drug Enforcement Administration": DEA Active Controlled Substances Act (CSA) Registrants Database. Registration under the Act enables physicians, related practitioners, other established health organizations, pharmaceutical companies, and others to prescribe and handle controlled substances

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Prescriber Validation Error	Reject Code (511-FB)	Additional Message Information Qualifier(s) (132-UH)	Additional Message Information (526-FQ)	Description of Invalid Provider Data Source
	44 Plan's Prescriber data base indicates the Prescriber DEA Number Is not found 46 Plan's Prescriber database indicates Prescriber DEA Number does not allow this drug DEA class			
Prescriber's state license has been identified as not active/valid	777 Plan's Prescriber database not able to verify active state license with prescriptive authority for Prescriber ID Submitted	26 - INVALID PROVIDER DATA SOURCE & 27 – INVALID PROVIDER DATA SOURCE STATE CODE	**"STATE LICENSE"** **&** **2-character State Code of the applicable State Licensing Board file. Refer to state abbreviations within the ECL SHARED CODE LIST: State/Province Address**	Data from a state board or other state regulatory agency identifying individuals' and entities' license status to practice within a designated discipline and locality.

Added September 2026

3.9.3.1 Medicare Part D Provider Validation Flow

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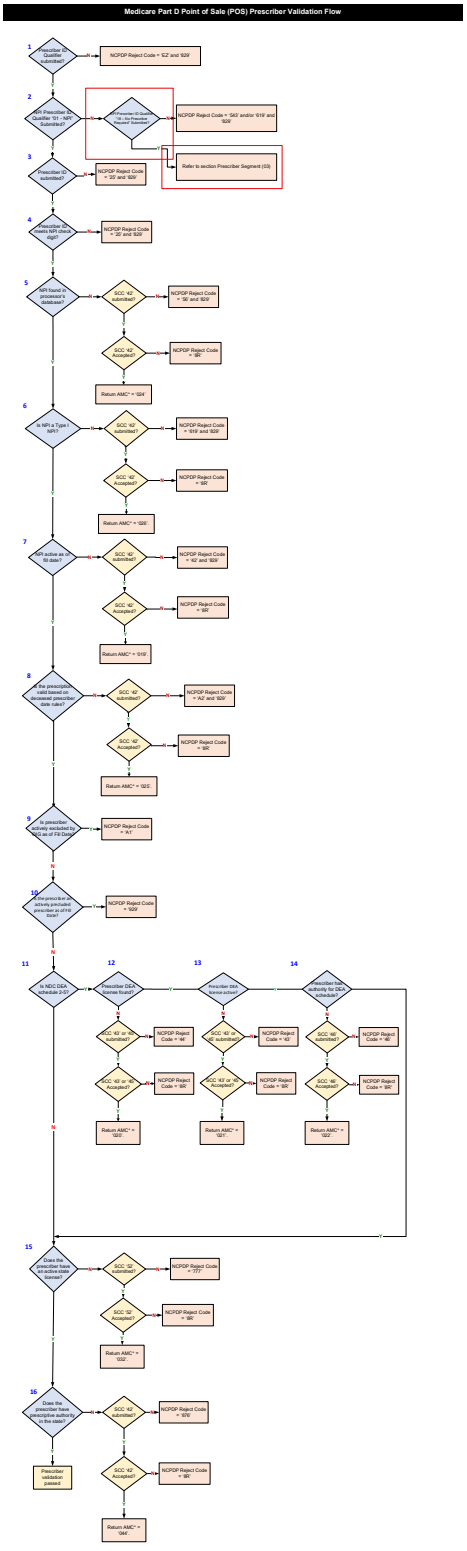

Note: Reject Code (511-FB) value 829 may not be returned with Reject Code (511-FB) value 569 because it is not appealable.

829 = Pharmacy Must Notify Beneficiary: Claim Not Covered Due To Failure To Meet Medicare Part D Active, Valid Prescriber NPI Requirements.

569 = Provide Note: Medicare Prescription Drug Coverage and Your Rights

*Processor/PBM may reject transaction for other reasons such as formulary restrictions, safety edits (DUR), etc. post prescriber validation. So long as no other rejections occur, a paid transaction should return specified AMC.

Prescriber validation will cease after pharmacy verification as indicated with a Submission Clarification Code and acceptance by the processor as indicated with an Approved Message Code. Retrospective review may occur by the processor.

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3.9.3.2 Medicare Part D Prescriber Validation Reject Matrix

The below matrix provides the steps and recommended edit order to validate the various prescriber aspects when processing Medicare Part D claims. The matrix is based on the current state of the industry as of Fall 2024.

Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
1	Prescriber ID Qualifier (466-EZ) is not Submitted	EZ	M/I Prescriber ID Qualifier	829	N/A	N/A	N/A	N/A	N/A	N/A
2	Prescriber ID Qualifier (466-EZ) is not "01 – NPI" or "18 – No Prescriber Required" (e.g., ID = 17 Foreign Prescriber)	543 And/Or 619	Prescriber ID Qualifier Value Not Supported Prescriber Type 1 NPI Required	829	N/A	N/A	N/A	N/A	N/A	N/A
3	Prescriber ID (411-DB) is not Submitted	25	M/I Prescriber ID	829	N/A	N/A	N/A	N/A	N/A	N/A
4	Prescriber ID (411-DB) does	25	M/I Prescriber ID	829	N/A	N/A	N/A	N/A	N/A	N/A

Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
	not Meets NPI Check Digit									
5	NPI is not found in processor's database	56	Non-Matched Prescriber ID Task Group Comment: Used when the submitted Prescriber ID meets the format/check digit but is not found in the processor/payer prescriber database.	829	42	Prescriber ID Submitted is valid and prescribing requirements have been validated Task Group Comment: If pharmacy submits SCC 42 and then	024	The submitted Prescriber ID is Not Found – Flagged for Retrospective Review	8R	Submission Clarification Code Value Not Supported

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
						the NPI is found not valid, the PDE will reject.				
6	NPI is not Type 1 NPI	619	Prescriber Type 1 NPI Required	829	42	Prescriber ID Submitted is valid and prescribing requirements have been validated	026	Prescribe Type 1 NPI Required - Flagged for Retrospective Review	8R	Submission Clarification Code Value Not Supported

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
7	NPI is not active as of Fill Date	42	Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired	829	42	Prescriber ID Submitted is valid and prescribing requirements have been validated	019	The Submitted Prescriber ID is inactive or expired - Flagged for Retrospective Review The claim paid, however, the combination of Prescriber ID	8R	Submission Clarification Code Value Not Supported

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
								Qualifier (466-EZ) and Prescriber ID (411-DB) provided on the transaction was inactive or expired in the processor's system.		

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
8	Prescription is not Valid Based on Deceased Prescriber Date Rules	A2	ID Submitted is associated to a Deceased Prescriber	829	42	Prescriber ID Submitted is valid and prescribing requirements have been validated.	025	The submitted Prescriber ID is associated to a Deceased Prescriber – Flagged for Retrospective Review	8R	Submission Clarification Code Value Not Supported
9	Prescriber ID is Actively Excluded by OIG as of Fill Date	A1	ID Submitted is Associated with an Excluded Prescriber	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
10	Prescriber is Actively Precluded as of Fill Date	929	ID Submitted Is Associated With A Precluded Prescriber	N/A	N/A	N/A	N/A	N/A	N/A	N/A
11	Is NDC DEA Schedule 2 – 5? If yes, continue to step 12. If no, continue to step 15.									

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
12	Prescriber DEA License is not Found	44	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found	N/A	43 45	Prescriber's DEA is active with DEA Authorized Prescriptive Right. Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule	020	For the Submitted Prescriber ID, the associated DEA Number is Not Found – Flagged for Retrospective Review Value Limitation: Value definition sunsetted for use in	8R	Submission Clarification Code Value Not Supported

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
								Telecommunication Version EB and greater.		
13	Prescriber DEA License is not Active	43	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive	N/A	43 45	Prescriber's DEA is active with DEA Authorized Prescriptive Right. Prescriber's DEA is a	021	For the Submitted Prescriber ID, the associated DEA Number is Inactive or Expired – Flagged	8R	Submission Clarification Code Value Not Supported

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
						valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule		for Retrospective Review. Value Limitation: Value definition sunsetted for use in Telecommunication Version EB and greater.		
14	Prescriptive Authority not met for DEA Schedule	46	Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does	N/A	46	Prescriber's DEA has prescriptive authority for this	022	The submitted Prescriber DEA does not allow	8R	Submission Clarification Code Value Not Supported

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
			not allow this drug DEA Schedule			drug DEA Schedule		this drug DEA Schedule – Flagged for Retrospective Review Value Limitation: Value definition sunsetted for use in Telecommunication Version EB or greater.		

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
15	Prescriber does not have Active State License	777	Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted	N/A	52	Prescriber's state license with prescriptive authority has been validated-Indicates the prescriber ID submitted is associated to a healthcare provider with the	032	Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted, flagged for retrospective review.	8R	Submission Clarification Code Value Not Supported

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
						applicable state license that grants prescriptive authority.				
16	Prescriber does not have Prescriptive Authority in the State	876	Prescriptive Authority Restrictions Apply, Criteria Not Met Comment: Used when state regulatory restrictions are imposed on specific prescriber types (e.g., mid-level practitioners such as pharmacists, nurse	N/A	42	Prescriber ID Submitted is valid and prescribing requirements have been validated.	044	Plan's Prescriber database determined prescriptive authority criteria not met, flagged for retrospec	8R	Submission Clarification Code Value Not Supported

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Validation Step		Processor Response if Step Not Met			Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
Edit Order (Suggested)	Scenario: If scenario met, follow rejects, SCCs and AMCs	Reject Code 511-FB	Reject Code Description	Appeal or MACRA (Secondary Reject Code: Not Stand-alone)	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
			practitioners and physician assistants). Additional messaging should describe criteria not met.			Value Limitation: Value of 42 does not apply to prescriber enrollment status.		tive review. Value Limitation: To be returned when reject code 876 applied and SCC 42 was accepted.		

Note: Reject Code (511-FB) value 829 may not be returned with Reject Code (511-FB) value 569 because it is not appealable.
829 = Pharmacy Must Notify Beneficiary: Claim Not Covered Due To Failure To Meet Medicare Part D Active, Valid Prescriber NPI Requirements.
569 = Provide Notice: Medicare Prescription Drug Coverage and Your Rights

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*Processor/PBM may reject transaction for other reasons such as formulary restrictions, safety edits (DUR), etc. post prescriber validation. So long as no other rejections occur, a paid transaction should return specified AMC.

The processor cannot validate prescriber authority if the NPI is not on file in the processor's system. Prescriber validation will cease after pharmacy verification as indicated with a Submission Clarification Code and acceptance by the processor as indicated with an Approved Message Code. Retrospective review may occur by the processor.

Added September 2026

3.9.3.3 Medicaid Provider Validation Flow

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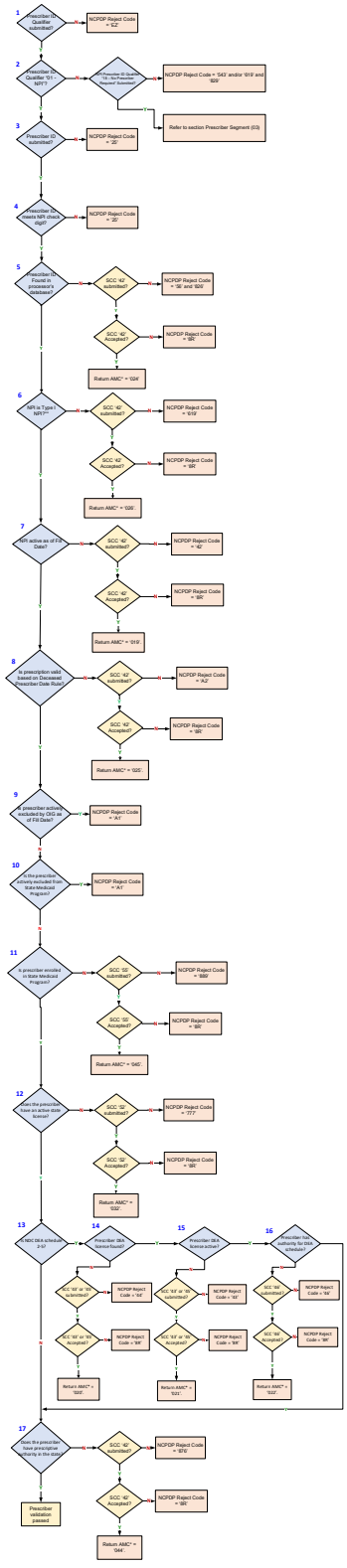
Medicaid Part D Point of Sale (POS) Prescriber Validation Flow



*Processor/PBM may reject transaction for other reasons such as formulary restrictions, safety edits (DUR), etc. post prescriber validation. So long as no other rejections occur, a paid transaction should return specified AMC.

The processor cannot validate prescriber authority if the NPI is not on file in the processor's system. Prescriber validation will cease after pharmacy verification as indicated with a Submission Clarification Code and acceptance by the processor as indicated with an Approved Message Code. Retrospective review may occur by the processor.

**Industry feedback indicates Medicaid claims processing is usually limited to Type 1 NPI prescriber ID only. Other Prescriber ID Qualifier (466-E2) may be accepted based on trading partner agreement.

3.9.3.4 Medicaid Prescriber Validation Reject Matrix

The matrix below provides the steps and recommended edit order to validate the various prescriber aspects when processing Medicaid claims. The matrix is based on the current state of the industry as of Winter 2025.

Validation Step Edit Order (Suggested)	Scenario– If scenario met, follow rejects, SCCs and AMCs	Processor Response if Step Not Met		Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
		Reject Code 511-FB	Reject Code Description	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
1	Prescriber ID Qualifier (466-EZ) is not Submitted	EZ	M/I Prescriber ID Qualifier	N/A	N/A	N/A	N/A	N/A	N/A
2	Prescriber ID Qualifier (466-EZ) is not ”01 – NPI” or “18 – No Prescriber Required””	543 and/or 619	Prescriber ID Qualifier Value Not Supported Prescriber Type 1 NPI Required	N/A	N/A	N/A	N/A	N/A	N/A
3	Prescriber ID (411-DB) is not Submitted	25	M/I Prescriber ID	N/A	N/A	N/A	N/A	N/A	N/A
4	Prescriber ID (411-DB) does not meet Prescriber ID Meets NPI Check Digit	25	M/I Prescriber ID	N/A	N/A	N/A	N/A	N/A	N/A
5	Prescriber ID is not Found in Processor's Database	56 or	Non-Matched Prescriber ID	42	Prescriber ID Submitted is valid and prescribing requirements have been validated. Value Limitation: Value of 42 does	024	The submitted Prescriber ID is Not Found – Flagged for Retrospective Review	8R	Submission Clarification Code Value Not Supported

Validation Step Edit Order (Suggested)	Scenario– If scenario met, follow rejects, SCCs and AMCs	Processor Response if Step Not Met		Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
		Reject Code 511-FB	Reject Code Description	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
		826	Prescriber NPI Submitted Not Found Within Processor's NPI File		not apply to prescriber enrollment status. Additional Guidance: SCC 42 does not indicate the pharmacy validated prescriber enrollment in Medicaid.				
6	NPI is not Type 1 NPI**	619	Prescriber Type 1 NPI Required	42	Prescriber ID Submitted is valid and prescribing requirements have been validated Value Limitation: Value of 42 does not apply to prescriber enrollment status.	026	Prescriber Type 1 NPI Required - Flagged for Retrospective Review	8R	Submission Clarification Code Value Not Supported
7	NPI is not Active as of Fill Date	42	Plan's Prescriber Database Indicates The Prescriber ID Submitted Is Inactive Or Expired	42	Prescriber ID Submitted is valid and prescribing requirements have been validated Additional Guidance: SCC 42 does not indicate the pharmacy validated prescriber	019	The Submitted Prescriber ID is inactive or expired - Flagged for Retrospective Review. *The claim paid; however, the combination of Prescriber ID Qualifier (466-EZ) and Prescriber ID*	8R	Submission Clarification Code Value Not Supported

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Validation Step Edit Order (Suggested)	Scenario– If scenario met, follow rejects, SCCs and AMCs	Processor Response if Step Not Met		Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
		Reject Code 511-FB	Reject Code Description	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
					enrollment in Medicaid.		*(411-DB) provided on the transaction was inactive or expired in the processor's system.*		
8	Prescription is not Valid Based on Deceased Prescriber Date Rule	A2	ID Submitted Is Associated To A Deceased Prescriber	42	Prescriber ID Submitted is valid and prescribing requirements have been validated Additional Guidance: SCC 42 does not indicate the pharmacy validated prescriber enrollment in Medicaid.	025	The submitted Prescriber ID is associated to a Deceased Prescriber - Flagged for Retrospective Review.	8R	Submission Clarification Code Value Not Supported
9	Prescriber ID is not Actively Excluded by OIG as of Fill Date	A1	ID Submitted Is Associated With An Excluded Prescriber	N/A	N/A	N/A	N/A	N/A	N/A
10	Prescriber is not Actively Excluded from State Medicaid Program	A1	ID Submitted Is Associated With An Excluded Prescriber	N/A	N/A	N/A	N/A	N/A	N/A

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Validation Step Edit Order (Suggested)	Scenario– If scenario met, follow rejects, SCCs and AMCs	Processor Response if Step Not Met		Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
		Reject Code 511-FB	Reject Code Description	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
11	Prescriber is not Enrolled in State Medicaid Program	889	Prescriber Not Enrolled in State Medicaid Program	55	Prescriber Enrollment in State Medicaid Program has been validated.	045	Prescriber active enrollment with Medicaid Fee For Service/MCO required. Flagged for retrospective review. Value Limitation: Value returned only if Submission Clarification Code 55 (Prescriber Enrollment in State Medicaid Program has been validated) was accepted.	8R	Submission Clarification Code Value Not Supported
12	Prescriber does not have Active State License	777	Plan's Prescriber Database Not Able to Verify Active State License With Prescriptive Authority For Prescriber ID Submitted	52	Prescriber's state license with prescriptive authority has been validated. *Indicates the prescriber ID submitted is associated to a healthcare provider with the applicable state license that grants prescriptive authority.*	032	Plan's Prescriber database not able to verify active state licenses with prescriptive authority for Prescriber ID Submitted, flagged for retrospective review.	8R	Submission Clarification Code Value Not Supported
13	Is NDC DEA Schedule 2 – 5?								

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Validation Step Edit Order (Suggested)	Scenario– If scenario met, follow rejects, SCCs and AMCs	Processor Response if Step Not Met		Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
		Reject Code 511-FB	Reject Code Description	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
	If yes, continue to step 14. If no, continue to step 17.								
14	Prescriber DEA License is not Found	44	Plan's Prescriber Database Indicates The Prescriber DEA Number Is Not Found	43 45	Prescriber's DEA is active with DEA Authorized Prescriptive Right. Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule.	020	Prescriber DEA number is not found in processor's system. Paid claim flagged for retrospective review. Value Limitation: Used in Telecommunication Standard Version EB© or greater but not in lower versions.	8R	Submission Clarification Code Value Not Supported
15	Prescriber DEA License is not Active	43	Plan's Prescriber Database Indicates The Prescriber DEA Number Is Inactive or Expired	43 45	Prescriber's DEA is active with DEA Authorized Prescriptive Right. Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule.	021	Prescriber DEA number in the processor's system is inactive/expired. Paid claim flagged for retrospective review. Value Limitation: Used in Telecommunication Standard Version EB© or greater but not in lower versions.	8R	Submission Clarification Code Value Not Supported

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Validation Step Edit Order (Suggested)	Scenario– If scenario met, follow rejects, SCCs and AMCs	Processor Response if Step Not Met		Pharmacy Response to Processor Reject		Processor Returns Value if SCC Accepted		Processor Returns Value if SCC Rejected	
		Reject Code 511-FB	Reject Code Description	SCC 420-DK	SCC Description	AMC* 548-6F	AMC Description	Reject Code 511-FB	Reject Code Description
16	Prescriptive Authority not met for DEA Schedule	46	Plan's Prescriber Database Indicates The Prescriber DEA Number Does Not Allow This Drug DEA Class	46	Prescriber's DEA has prescriptive authority for this drug DEA Schedule	022	Prescriber DEA number in the processor's system does not allow for this drug DEA schedule. Paid claim flagged for retrospective review. Value Limitation: Used in Telecommunication Standard Version EB© or greater but not in lower versions.	8R	Submission Clarification Code Value Not Supported
17	Prescriber does not have Prescriptive Authority in the State	876	Prescriptive Authority Restrictions Apply, Criteria Not Met	42	Prescriber ID Submitted is valid and prescribing requirements have been validated. Additional Guidance: SCC 42 does not indicate the pharmacy validated prescriber enrollment in Medicaid.	044	Plan's Prescriber database determined prescriptive authority criteria not met, flagged for retrospective review. Value Limitation: To be returned when reject code 876 applied and SCC 42 was accepted.	8R	Submission Clarification Code Value Not Supported

*Processor/PBM may reject transaction for other reasons such as formulary restrictions, safety edits (DUR), etc. post prescriber validation. So long as no other rejections occur, a paid transaction should return the specified AMC. The processor cannot validate prescriber authority if the NPI is not on file in the processor's

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system. Prescriber validation will cease after pharmacy verification as indicated with a Submission Clarification Code and acceptance by the processor as indicated with an Approved Message Code. Retrospective review may occur by the processor.

**Industry feedback indicates Medicaid claims processing is usually limited to Type 1 NPI prescriber ID only. Other Prescriber ID Qualifier (466-EZ) may be accepted based on trading partner agreement.

Added September 2026

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3.10 Request Coordination of Benefits/Other Payments Segment (05)

3.10.1 Other Payer Adjudicated Program Type (C47-9T)

Question: How should the Other Payer Adjudicated Program Type (C47-9T) be populated in the Coordination of Benefits/Other Payments Segment of the claim billing transaction?

Answer: The pharmacy should populate the Other Payer Adjudicated Program Type (C47-9T) with the value returned by each of the previous payers in the Adjudicated Program Type (A28-ZR) field in their respective transactions. See section 28.3 of the *NCPDP Telecommunication Standard Version F6 Implementation Guide*©.

Added May 2025

Question: If the downstream payer does not coordinate benefits with the program type submitted in the Other Payer Adjudicated Program Type (C47-9T), can the payer reject the claim?

Answer: Yes, the payer should reject the claim with the most appropriate Reject Code (511-FB). Some possibilities include:

- DI8: Other Payer Adjudicated Program Type Value Not Supported (C47-9T)
- 887: A Previous Payer(s) Is An Excluded Federal Health Care Program Copay Assistance Is Not Allowed
- 888: Beneficiary Is Enrolled In Excluded Federal Health Care Program

Added May 2025

3.10.2 Populating Other Payer Date

Question: Does the Other Payer Date (443-E8) have to match the Date of Service (401-D1)?

Answer: No, the Other Payer Date (443-E8) does not have to match the Date of Service (401-D1).

The definition of Other Payer Date (443-E8) is, “Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.”

The definition of Date of Service (401-D1) is, “Identifies date the prescription was filled or professional service rendered or subsequent payer began coverage following Part A expiration in a long-term care setting only.” In the retail pharmacy setting, the Date of Service (401-D1) represents the date the prescription was filled or administered in the case of vaccines.

When additional coverage is known at the time the prescription is filled, the Other Payer Date (443-E8) will typically match the Date of Service (401-D1) as the COB claim will process immediately after the primary is billed. When additional coverage is identified after the prescription is picked up (or administered), the pharmacy protocol may require the reversal and resubmission of the original claim in order to process the COB claim.

For example, the claim was filled on 9/2/2025 and the COB coverage was identified on 9/4/2025. The two fields in the COB transaction would be populated as follows:

Date of Service	401-D1	20250902

Other Payer Date	443-E8	20250904

The Other Payer Date (443-E8) is based on the last adjudication for this fill to the previous payer. Because this was billed to the primary payer again on 9/4/2025, the Other Payer Date (443-E8) is 9/4/2025, which is different from the Date of Service (401-D1).

Added December 2025

3.10.3 Other Payer Percentage Tax Exempt Indicator (D51-P7) and Other Payer Regulatory Fee Exempt Indicator (D52-P8)

Question: Are the Other Payer Percentage Tax Exempt Indicator (D51-P7) and Other Payer Regulatory Fee Exempt Indicator (D52-P8) values a direct map from the values returned in the Percent Tax Exempt Indicator (557-AV) and Regulatory Fee Exempt Indicator (D62-RM) fields?

Answer: No, the Request COB Other Payer Percentage Tax Exempt Indicator (D51-P7) values are not a direct map from Percentage Tax Exempt Indicator (557-AV); however, the Other Payer Regulatory Fee Exempt Indicator (D52-P8) values *are* a direct map from the Regulatory Fee Exempt Indicator (D62-RM) values.

Field 557-AV was renamed from Sales Tax Exempt Indicator to Percentage Tax Exempt Indicator when Regulatory Fee was broken out for the Telecommunication Standard VF2©. Because of this, several old values were sunset, leaving only values 1, 5, 6, and 7. The mapping from the response field Percentage Tax Exempt Indicator (557-AV) to the request COB Segment field Other Payer Percentage Tax Exempt Indicator (D51-P7) is shown in the chart below.

Percentage Tax Exempt Reason	Response Field 557-AV Percentage Tax Exempt Indicator	Request Field D51-P7 Other Payer Percentage Tax Exempt Indicator
Plan Tax Exempt	1	1
Religious Organization	5	2
Tax Exempt Certificate	6	3
Previous Payer Exempt	7	4

The request COB Other Payer Regulatory Fee Exempt Indicator (D52-P8) values are a direct map from the Regulatory Fee Exempt Indicator (D62-RM) values, as shown in the chart below.

Regulatory Fee Exempt Reason	Response Field D62-RM	Request Field D52-P8

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	Regulatory Fee Exempt Indicator	Other Payer Regulatory Fee Exempt Indicator
Plan Regulatory Fee Exempt	1	1
Religious Organization	2	2
Regulatory Exempt Certificate	3	3
Previous Payer Exempt	4	4

Added March 2026

3.10.4 Other Payer Amount Paid (OPAP) Occurrences

Question: How does a pharmacy report Other Payer Amount Paid (OPAP) occurrences and calculate Drug Benefit in OPAP COB transactions?

Answer: Although the financial fields within the COB Segment are considered pass through fields, where the provider is reporting what was received from the previous payers' responses, the pharmacy is required to perform some calculations for OPAP COB. To accurately determine the amounts to be reported in the Other Payer Amount Paid (431-DV) field(s), a specific order of Other Payer Amount Paid Qualifiers (342-HC) must be followed.

- Order is based on the payment being associated to provider versus state revenue, the dispensing of a product, and any value-added services (e.g., delivery, postage, etc.).
- Drug Benefit (Other Payer Amount Paid Qualifier (342-HC) value 07) is the end result, after all Other Payer Amount Paid values are subtracted from Total Amount Paid (509-F9).
- Drug Benefit is always required in OPAP or Government COB.

See the chart below for the OPAP COB reporting order.

COB CLAIM 342-HC REPORTING ORDER	OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) VALUE	DESCRIPTION	NOTES
1	12	**Regulatory Fee** - An indicator which signifies the amount paid by the other payer related to a regulatory fee.	Neither Product nor Service, not part of Sales. Any Regulatory Fee amount paid by the previous plan(s) should be the 1st amount reported to downstream payer. If payer does not pay Regulatory Fee, then they cannot use regulatory fees paid by prior payer(s) to reduce payment obligations or use towards other payer amount recognized amount reported.
2		**Percentage Tax** - An indicator which signifies the amount paid by the other payer related to percentage tax.	Neither Product nor Service, not part of Sales. Any Percentage Tax amount paid by the previous plan(s) should be

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COB CLAIM 342-HC REPORTING ORDER	OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) VALUE	DESCRIPTION	NOTES
	15		the 2nd amount reported to downstream payer. If payer does not pay Percentage Tax, then they cannot use percentage taxes paid by prior payer(s) to reduce payment obligations or use towards other payer amount recognized amount reported.
3	09	**Compound Preparation Cost** – An indicator which signifies the dollar amount paid by the other payer which is related to the preparation of the compound.	The product cannot be dispensed without the compound prep.
4	01	**Delivery** – An indicator which signifies the dollar amount paid by the other payer which is related to the delivery of a product or service.	Value Added Service
5	02	**Shipping** – An indicator which signifies the dollar amount paid by the other payer which is related to the transportation of a product.	Value Added Service
6	03	**Postage** – An indicator which signifies the dollar amount paid by the other payer which is related to the mailing of a product.	Value Added Service
7	04	**Administrative** – An indicator which signifies the dollar amount paid by the other payer which is related to administrative activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance.	Value Added Service
8	16	**Medication Synchronization** – An indicator which signifies the amount paid by the other payer related to the process of coordinating a patient's prescription refills to be picked up on the same day each month.	Value Added Service
9	17	**Adherence (Compliance)** Packaging – An indicator which signifies the amount paid by the other payer related to the packaging of medications in a manner that helps patients take their medications correctly and on time. This packaging often includes features like labeled compartments for different times of the day or days of the week, making it easier to follow the prescribed medication schedule.	Value Added Service
10	05	**Incentive -** An indicator which signifies the dollar amount paid by the other payer which	Value Added Service

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COB CLAIM 342-HC REPORTING ORDER	OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) VALUE	DESCRIPTION	NOTES
		is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g. collection of survey data, counseling plan enrollees, vaccine administration).	
11	07	**Drug Benefit** – An indicator which signifies the dollar amount paid by the other payer which is related to the plan's drug benefit.	END RESULT of subtracting all Other Payer Amount Paid values from Total Amount Paid (509-F9)

Added March 2026

3.11 Request Workers' Compensation Segment (06)

3.12 Request DUR/PPS Segment (08)

3.12.1 Duplicate DUR Request Segments

Question: Does the NCPDP *Telecommunication Standard©* support transmitting two occurrences within the DUR/PPS Segment in a B1 Claim Request with the same Reason for Service Code (439-E4), Professional Service Code (440-E5) and Result of Service Code (441-E6)? For example, there are instances when a Payer/Processor will return multiple occurrences within the Response DUR/PPS Segment of the Claim Response with the same Reason for Service Code, expecting the pharmacy to respond to each independently. This would result in the pharmacy needing to submit a new B1 Claim Request with two or more occurrences in the DUR/PPS Segment with identical Reason for Service Code, Professional Service Code and Result of Service Code values (see example below).

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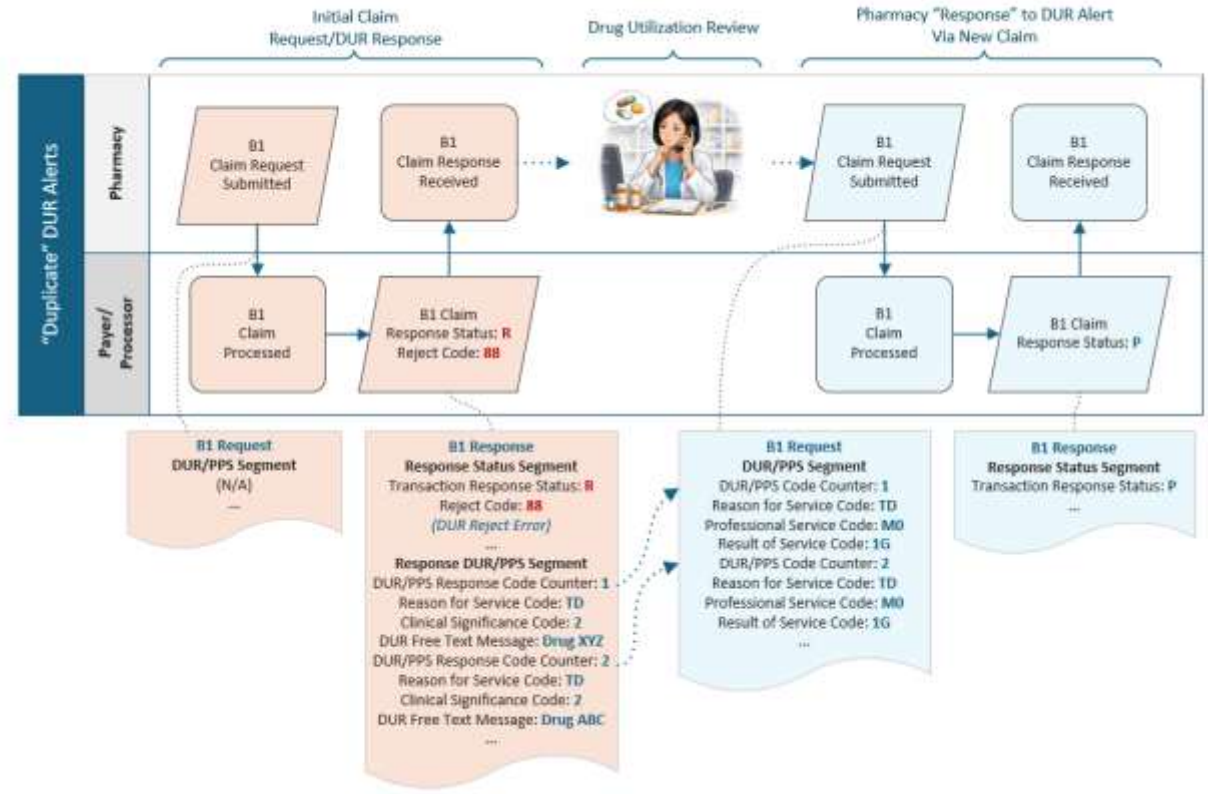

Answer: Yes. The NCPDP *Telecommunication Standard*© does support transmitting multiple occurrences within the DUR Segment within a single B1 Claim Request—even when those occurrences contain the same Reason for Service Code (e.g., *TD – Therapeutic Duplication*), Professional Service Code and Result of Service Code.

The Standard does not prohibit sending two or more occurrences within the DUR/PPS Segment with identical Reason for Service Code, Professional Service Code and Result of Service Code values when a processor or payer has generated multiple DUR alerts that require individual responses. In such cases, each DUR alert represents a distinct interaction that the pharmacy must address, even if the interaction types are the same.

Pharmacy systems should allow multiple occurrences within the DUR/PPS Segment to be transmitted and should not automatically suppress an occurrence simply because it appears duplicative. Removing an occurrence may prevent the payer/processor from recognizing that all required DUR alerts have been addressed, resulting in continued claim rejection.

When multiple DUR alerts are returned, the pharmacy should respond to them in the same order in which they were received.

Payers and processors are encouraged to review the *Telecommunication Implementation Guide*© section titled "*The Problem of Noise*" and should consolidate alerting where appropriate. Duplicate alerts for the

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same interaction within a member's claim history should be avoided to reduce unnecessary burden on pharmacies and prevent redundant DUR responses.

Added June 2026

3.13 Request Pricing Segment (11)

3.14 Request Compound Segment (10)

3.15 Request Prior Authorization Segment (12)

3.16 Request Clinical Segment (13)

3.17 Request Additional Documentation Segment (14)

3.18 Request Facility Segment (15)

3.19 Request Narrative Segment (16)

3.20 Request Intermediary Segment (19)

3.20.1 Segment Not Used

Question: What should processors do when they receive an Intermediary Segment on Telecommunication VF6 transactions, such as B1 and B3, and the processor does not use the Intermediary Segment?

Answer: F6 Implementation Guide Section 8.3 states, "Note, if the sender chooses to send in more fields than are required or situational by the receiver, but which the sender needs for their business, the receiver is to ignore these fields or segments."

As a result:

- Processors should not reject a transmission with an Intermediary Segment, solely based on the presence of that segment.
- Processors should always include the Intermediary Segment on their payer sheets. If segment is not used for processing, processors should select "Not used by processor/may be (situationally) required by intermediary" in the dropdown box on the payer sheet template.
- Processors do not need to but may validate the individual Intermediary Segment fields when not used for processing.
- Intermediaries and/or processors should include a fully detailed Intermediary Segment on their payer sheets if using the Intermediary Segment for processing.

Added December 2025

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3.21 Request Last Known 4Rx Segment (37)

3.22 Request N Transaction Payer Identification Segment (38)

3.23 Response Header Segment

3.24 Response Message Segment (20)

3.25 Response Insurance Segment (25)

3.26 Response Insurance Additional Information Segment (27)

3.27 Response Patient Segment (29)

3.27.1 Patient ID (332-CY)

Question: What is expected to be returned by the PBM/processor in Patient ID (332-CY) on the response?

Answer: The Response Patient ID (332-CY) field allows PBMs/processors to share patient identifiers with pharmacies to:

- Improve the accuracy of patient data exchange
- Support care coordination and benefit alignment

This field was introduced so stakeholders could communicate in standard transactions a patient identifier either issued by a government agency (such as Social Security Number, State-issued, Indian Tribal), private entity (such as NCPDP's UPI) or others.

The field supports up to nine entries, enabling the PBM/processor to return multiple identifiers if needed.

Scenario-Based Guidance

Scenario 1: Mismatched UPIs from the Same Enumerator

- **Situation:** Both the pharmacy and PBM have UPIs from NCPDP, but the UPI submitted by the pharmacy does not match the PBM's record
- **PBM/Processor Options:**
    1. Return the UPI on file with qualifier (331-CX) = 15 (NCPDP UPI)
    2. Return nothing/blank
- **Purpose:** To inform the pharmacy that the PBM has a different UPI from the same source.

Option	Submitted Qualifier	Submitted Patient ID	Response Qualifier(s)	Response Patient ID(s)
1	15 (NCPDP Universal Patient Identifier (UPI))	ABC12345	15 (NCPDP Universal Patient Identifier (UPI))	ABC13345
2	15 (NCPDP Universal Patient Identifier (UPI))	ABC12345		

Scenario 2: Different UPI Enumerators

- **Situation:** Both the pharmacy and PBM have UPIs for the patient, but from different enumerating entities

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- **PBM/Processor Options:**
    1. Return their UPI with the appropriate qualifier (331-CX) for their enumerator
    2. Return nothing/blank
- **Purpose:** To indicate that the patient has a UPI from a different source.

Option	Submitted Qualifier	Submitted Patient ID	Response Qualifier(s)	Response Patient ID(s)
1	16 (LexID) Universal Patient Identifier (UPI))	ABC123XYZ	18 (Evernorth) Universal Patient Identifier (UPI))	XYZ789ABC
2	16 (LexID Universal Patient Identifier (UPI))	ABC123XYZ		

Scenario 3: Submitted Patient ID Does Not Match PBM Records

- **Situation:** The pharmacy submits a patient ID (e.g., SSN) that does not match the PBM's records
- **PBM/Processor Options:**
    1. Return the ID they have on file, even if it doesn't match the submitted one
    2. If multiple IDs are on file, return any acceptable value
    3. Return nothing/blank
- **Purpose:** To provide the pharmacy with the PBM's known identifiers for potential reconciliation.

Option	Submitted Qualifier	Submitted Patient ID	Response Qualifier(s)	Response Patient ID(s)
1	01 (SSN)	999-99-9999	01 (SSN)	888-88-8888
2	01 (SSN)	999-99-9999	18 (Evernorth Universal Patient Identifier (UPI))	ABC123
			09 (Medicare Beneficiary ID)	XYZ789
3	01 (SSN)	999-99-9999		

Additional Resources:
For more detailed use cases and recommendations, refer to the Universal Patient Identifier Guidance Document.

Added August 2025

3.28 Response Status Segment (21)

3.28.1 N Transaction – Medicare Part D Payer to Payer

Question: What values should be provided in the Response Status Segment for a Medicare Part D Payer to Payer response when the help desk support type is not needed in the N Transaction?

Answer:

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- In the Mandatory Help Desk Support Type Count (C72-BH) provide a default value of 1.
- In the Mandatory Help Desk Support Type (C71-BG) provide a default value of 4 (Other Payer - N1 Reporting).
- In the Required Help Desk Business Unit Type Count (C67-BB) provide a default value of 1.
- In the Situational Help Desk Business Unit Type (C66-BA) provide a default value of 1 (Pharmacy Help Desk).
- In the Situational Help Desk Contact Information Qualifier (C70-BF) provide a default value of 1 (Telephone Number).
- In the Situational Help Desk Contact Information (C68-BC) provide a default value of 9999999999 or put your help desk phone number here.

Added February 2023

3.28.2 Reconciliation ID

Question: What should a pharmacy do if a Reconciliation ID (B98-34) is not returned on an F6 claim response and the pharmacy needs to submit a related reversal or COB claim?

Answer: The Reconciliation ID (B98-34) field in the Claim Segment of a reversal (B2) and the Other Payer Reconciliation ID (C49-9V) field on a COB transaction are intended to report the Reconciliation ID (B98-34) value from the related Claim Billing response. If the pharmacy does not receive the Reconciliation ID from a processor/payer on an F6 claim response, the pharmacy should populate a value of "NOTAVAILABLE" for any subsequent related transactions.

Payers/processors must be prepared to recognize a value of "NOTAVAILABLE" as a valid value, since a more specific value may not always be available for the pharmacy to submit on Telecommunication Standard VF6© transactions. Reject Code (511-FB) values DB1 (M/I Reconciliation ID) and DH6 (M/I Other Payer Reconciliation ID) should not be used when the valid value of "NOTAVAILABLE" is submitted.

The Reconciliation ID (B98-34) field in the Claim Segment of a reversal (B2) is required, and a pharmacy must submit the field: if the field is missing, the payer/processor should reject with Reject Code (511-FB) value DB1 (M/I Reconciliation ID). As outlined in the Telecommunication Standard Implementation Guide VF6© (section 30.1.3), when the processor is unable to locate the original approved transaction using the Reconciliation ID (B98-34) and Service Provider ID (201-B1), it is recommended that the secondary match criteria using legacy reversal matching fields be used.

Payers/processors who receive "NOTAVAILABLE" on a reversal of an F6 claim should check their claim responses to ensure that the Reconciliation ID field is being populated appropriately.

The Other Payer Reconciliation ID (C49-9V) field is situational, and a payer/processor may reject with Reject Code (511-FB) value DH6 (M/I Other Payer Reconciliation ID) if it is not submitted and the payer/processor requires the field to be sent.

Added December 2025

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3.28.3 Reject Code

Question: What reject code should be used when a field from Version D.0, such as the Home Plan field (314-CE), is submitted on a Version F6 transaction where the field is no longer available?

Answer: Payers/processors should return **Reject Code R8 – Syntax Error** to indicate the submitted field is not available as part of Version F6. Payers/processors should also include the field in error in the Additional Message Information field (526-FQ) to help the submitter identify and correct the issue. For example:

- Reject Code: R8
- Secondary Message Field: Field xxx-yy (field name, if known) is not a valid Version F6 field. The value of xxx, is optional. For example, "Field 314-CE (Home Plan) is not a valid Version F6 field" or "Field 99 is not a valid Version F6 field"

While reject codes like 239 (Home Plan Is Not Used For This Transaction Code) or CE (M/I Home Plan) are appropriate for a field not used in a specific transaction type (e.g., E1) or a value being submitted in the field is missing or invalid as defined by NCPDP guidance, R8 is preferred when the field is no longer defined in the F6 implementation guide for any transactions and its presence constitutes a syntax violation, not a semantic one.

Note: This guidance should be agnostic to the presence of a value in the field. Whether the field is populated or blank, its inclusion in a version F6 transaction is inappropriate.

Added December 2025

3.29 Response Claim Segment (22)

3.29.1 Combined Response from Two Separate Payers

Question: When a payer/processor or intermediary responds to a single transaction submitted by the pharmacy with the combined response from two separate payers, how can patient pay impacts and supplemental payer information be communicated in the F6 real-time claim response?

Answer: The NCPDP Claim Response is designed to support the data associated with one payer/transaction response. To allow clear indicators in a F6 claim response when a supplemental payer has reduced patient pay and that patient pay reduction is funded with a separate payment to pharmacy, the following ECL values are recommended for use:

1. To communicate the patient pay reduction, use Patient Pay Component Qualifier (C95-KQ) value "20 – Amount Attributed to Supplemental Assistance Program" and populate the negative amount in Patient Pay Component Amount (C93-KN). To balance the claim pricing response, Patient Pay Amount (505-F5) will be populated with the calculated sum of Patient Pay Component Amount (C93-KN). Total Amount Paid (509-F9) will be populated with the balanced sum recognizing the reduced patient pay amount.

2. To communicate the supplemental payer information in an adjudicated claim response, the supplemental payer, plan payment amount, adjudicated program type, and reconciliation ID can be included in the Additional Message Information (526-FQ) with the associated qualifier values of "39 –

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Supplemental Payer Information" and "40 – Supplemental Payer Information Line 2" in field Additional Message Information Qualifier (132-UH).

The supplemental payer information is provided together via a structured response in the 40-character Additional Message Information (526-FQ). This structured response is defined as:

Field Content	Field Order	Max Field Size	Values
Supplemental Payer ID Qualifier	1	2	All values available through standard field Other Payer ID Qualifier (339-6C).
Terminator	;	1	
Supplemental Payer ID	2	30	Appropriate value given the qualifier above, e.g., IIN, Plan Name, etc., following the format of field Other Payer ID (340-7C)
Terminator	;	1	
Supplemental Plan Payment Amount	3	12	Dollar amount of the plan payment using format of 999999999.99 with an explicit decimal point.
Terminator	;	1	
Supplemental Payer Adjudicated Program Type	4	3	All values available through standard field Adjudicated Program Type (A28-ZR).
Terminator	;	1	
Supplemental Payer Reconciliation ID	5	30	Unique identifier assigned by the supplemental processor for the supplemental transaction payment following the format of field Reconciliation ID (B98-34).

The entire structured response including the field terminators (;) is one continuous message. Therefore, regardless of where the 40-character limit of the Additional Message Information (526-FQ) field falls, the next instance of the Additional Message Information (526-FQ) field will pick up with the next character of the structured response. See Section 27.2.4.4 ADDITIONAL MESSAGE INFORMATION FIELDS of the Telecommunications Version F6 Implementation Guide© for detailed guidance on the use of these fields.

3. Examples

3.1 Supplemental Payer coupon program reduces patient pay by $65 and will separately fund that amount. Response Pricing segment is populated accordingly. The structured message in response does not exceed 40 characters in total.

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Response Pricing Segment			
Field	**Field Name**	**Value**	**Comments**
509-F9	Total Amount Paid	1700{	$170 Total Amount Paid ($105 paid from responding payer and $65 paid from supplemental payer)
505-F5	Patient Pay Amount	350{	$35 patient pay ($100 copay reduced by $65 supplemental)
C94-KP	Patient Pay Component Count	2	2 Occurrences
C95-KQ	Patient Pay Component Qualifier	05	Amount of Copay
C93-KN	Patient Pay Component Amount	1000{	$100 Copay
C95-KQ	Patient Pay Component Qualifier	20	Amount Attributed to Supplemental Assistance
C93-KN	Patient Pay Component Amount	650}	Negative $65 Amount representing a decrease in the patient responsibility
506-F6	Ingredient Cost Paid	2000{	$200 Ingredient Cost
507-F6	Dispensing Fee Paid	50{	$5 Dispensing Fee

Response Status Segment			
Field	**Field Name**	**Value**	**Comments**
132-UH	Additional Message Information Qualifier	39	Supplemental Payer Info

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526-FQ	Additional Message Information	10;YOUR DISCOUNT PROG;65.00;6;12345678	Coded response of the following values: 10-Payer Name; "Your Discount Prog"; $65.00 Plan Payment; 6-Manufacturer Sponsored Patient Pay Reduction Program; "12345678" Reconciliation ID

3.2 Supplemental Payer coupon program reduces patient pay by $110 and will separately fund that amount. Response Pricing segment is populated accordingly. The structured message in response exceeds 40 characters in total requiring a second instance of the Additional Message Information (526-FQ).

Response Pricing Segment			
Field	**Field Name**	**Value**	**Comments**
509-F9	Total Amount Paid	1650{	$165 Total Amount Paid ($55 paid from responding payer and $110 paid from supplemental payer)
505-F5	Patient Pay Amount	400{	$40 patient pay ($150 copay reduced by $110 supplemental)
C94-KP	Patient Pay Component Count	2	2 Occurrences
C95-KQ	Patient Pay Component Qualifier	05	Amount of Copay

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C93-KN	Patient Pay Component Amount	1500{	$150 Copay
C95-KQ	Patient Pay Component Qualifier	20	Amount Attributed to Supplemental Assistance
C93-KN	Patient Pay Component Amount	1100}	Negative $110 Amount representing a decrease in the patient responsibility
506-F6	Ingredient Cost Paid	2000{	$200 Ingredient Cost
507-F6	Dispensing Fee Paid	50{	$5 Dispensing Fee

Response Status Segment			
Field	**Field Name**	**Value**	**Comments**
132-UH	Additional Message Information Qualifier	39	Supplemental Payer Info
526-FQ	Additional Message Information	10;TRULY AWESOME DISCOUNT PROGRAM;110.00	Coded response of the following value: 10-Payer Name; “Truly Awesome Discount Program”; $110.00 Plan Payment
131-UG	Additional Message Information Continuity	+	Continuation indicator
132-UH	Additional Message Information Qualifier	40	Supplemental Payer Info Line 2
526-FQ	Additional Message Information	;6;12345678901234567892	Continuation of the coded response of the following information:

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			;6-Manufacturer Sponsored Patient Pay Reduction Program; "12345678901234567892" Reconciliation ID

Added September 2026

3.30 Response Other Payers Segment (28)

3.30.1 Other Payer Names

Question: What payer name information should be returned in the Other Payer ID (340-7C) and Other Payer Name (D23-M5) fields within the Response Other Payers Segment and when should these fields be populated?

Answer: When only the payer name of the other payer is known, the payer name should be returned in at least the Other Payer ID (340-7C) field. This field supports up to 30 characters. Return the defined short name or abbreviated name where applicable, to support the field length. When the payer name is returned as the Other Payer ID (340-7C), the Other Payer ID Qualifier (339-6C) must be returned with the value of 10 – Payer Name. Returning the applicable values in these fields allows the receiving system to initiate other coverage technical and operational workflows.

The payer name can also be returned in the **Other Payer Name (D23-M5**) field. This field supports up to 70 characters. Return the defined full payer name, up to the first 70 characters, abbreviating when necessary. When the Other Payer Name (D23-M50) is returned, the Other Payer ID (340-7C) should also be returned. The Other Payer ID (340-7C) may be the short payer name with Other Payer ID Qualifier (339-6C) value 10, the IIN with qualifier value 03 or any other valid Other Payer ID (340-7C) and Other Payer ID Qualifier (339-6C) combination. Returning other payer name information in Other Payer Name (D23-M5) supports any necessary discussion between the pharmacy and the patient.

Example 1: The known information about the other payer includes the payer name and cardholder ID

- The PBM/processor does not cover the product, and it is known to be covered under the medical benefit.
- PBM/processor returns the name of the medical benefit plan in the Other Payer ID (340-7C) and Other Payer Name (D23-M5) fields.

Excerpt from rejected response transaction:

RESPONSE STATUS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*21*	RESPONSE STATUS SEGMENT

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RESPONSE STATUS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
112-AN	TRANSACTION RESPONSE STATUS	M	*R*	Rejected
510-FA	REJECT COUNT	R	*1*	
511-FB	REJECT CODE	R	*817*	Pharmacy Benefit Exclusion, Covered Under Patient's Medical Benefit

RESPONSE OTHER PAYERS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*28*	RESPONSE OTHER PAYERS SEGMENT
355-NR	OTHER PAYER ID COUNT	M	*1*	One occurrence
338-5C	OTHER PAYER COVERAGE TYPE	M	*01*	Primary
D41-PQ	OTHER PAYER RELATIONSHIP TYPE	M	*MX*	Mutually Exclusive Benefits
D50-P6	OTHER PAYER BENEFIT CLASSIFICATION TYPE	M	*MEDICAL*	Medical Benefit
C47-9T	OTHER PAYER ADJUDICATED PROGRAM TYPE	M	*99*	Other
339-6C	OTHER PAYER ID QUALIFIER	Q	*10*	Payer Name – *Name of other payer*
340-7C	OTHER PAYER ID	Q	*ABC HEALTH PLAN*	Return up to 30 characters of the Payer Name, this may be a defined short name or abbreviated name
D23-M5	OTHER PAYER NAME	Q	*ABC HEALTH PLAN OF XX STATE, COUNTY AND CITY IN YOUR NEIGHBORHOOD*	Return up to 70 characters of the full payer name
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	Q		
356-NU	OTHER PAYER CARDHOLDER ID	Q	ABC123456789	
992-MJ	OTHER PAYER GROUP ID	Q		

Example 2: PBM/processor has other payer IIN/PCN and other payer name information

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- Patient's prescription benefits were transitioned to a new health plan, requiring new 4RX processing information.
- The PBM/processor rejects the claim and provides new 4RX information and the name of the new plan within the Response Other Payers Segment.

Excerpt from rejected response transaction:

RESPONSE STATUS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	M	*R*	Rejected
510-FA	REJECT COUNT	R	*1*	
511-FB	REJECT CODE	R	*69*	Date of Service After Coverage Terminated

RESPONSE OTHER PAYERS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*28*	RESPONSE OTHER PAYERS SEGMENT
355-NR	OTHER PAYER ID COUNT	M	*1*	One occurrence
338-5C	OTHER PAYER COVERAGE TYPE	M	*01*	Primary
D41-PQ	OTHER PAYER RELATIONSHIP TYPE	M	*CC*	Change in Coverage
D50-P6	OTHER PAYER BENEFIT CLASSIFICATION TYPE	M	*RX*	Prescription Benefit
C47-9T	OTHER PAYER ADJUDICATED PROGRAM TYPE	M	*3*	Commercial
339-6C	OTHER PAYER ID QUALIFIER	R	*03*	BIN/IIN
340-7C	OTHER PAYER ID	R	*12345600*	
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	Q	*OTHERPCN*	
356-NU	OTHER PAYER CARDHOLDER ID	Q	*19896351981*	
992-MJ	OTHER PAYER GROUP ID	Q	*HVE1835*	
D23-M5	OTHER PAYER NAME	Q	*HEALTH VALUE EQUITY PLAN*	This is the name of the other payer (up to 70 characters).

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Added February 2024

3.30.2 Adjudicated Program Type (A28-ZR)

Question: Which Adjudicated Program Type value(s) should a pet insurance or pet discount program return on a claim response?

Answer: If the claim processes under an insurance policy meeting the definition of pet insurance provided by the National Association of Insurance Commissioners (NAIC), then an adjudicated program type of "42 – Pet Insurance" should be returned. If the claim processes under a discount program, then an adjudicated program type of "5 – Self-Pay: Discount Program" should be returned.

Added August 2024

Question: When is it appropriate to return the Adjudicated Program Type (A28-ZR) value of "Unknown" on a claim response?

Answer: The Adjudicated Program Type (A28-ZR) field is required on paid, duplicate paid, captured, and duplicate captured responses. The Adjudicated Program Type value of 9 – "Unknown" can only be returned on a rejected response transaction when the reject occurs before the Adjudicated Program Type value can be determined (refer to ECL value limitation). The following are examples where the claim may reject prior to program type evaluation:

1. 05 – M/I Service Provider Number (this refers to the Service Provider ID (201-B1) in the header segment)
2. 07 – M/I Cardholder ID

In the following examples, it would **NOT** be appropriate to return an Adjudicated Program Type (A28-ZR) of Unknown as the program type should have been determined:

1. 75 – Prior Authorization Required
2. 76 – Plan Limitations Exceeded

Added August 2024; Updated May 2025

Question: How and when should the following adjudicated program type fields be used in the Telecommunication Standard Version F6© transactions?

- ADJUDICATED PROGRAM TYPE (A28-ZR)
- REPORTED ADJUDICATED PROGRAM TYPE (A29-ZS)
- OTHER PAYER ADJUDICATED PROGRAM TYPE (C47-9T)
- N PAYER ADJUDICATED PROGRAM TYPE (C48-9U)

Answer: The Adjudicated Program Type fields are used in both transaction requests and responses to describe the type of program that has or would adjudicate the claim transaction if submitted. The following tables and additional details list the use of these distinct fields by Transaction Code (103-A3) within the Telecommunication Standard vF6© request and response transactions.

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Transaction Requests

The following fields are used in transaction requests, and the associated values are listed under the "Adjudicated Program Type" ECL Shared Code List.

Segment	Field	Field Name	Field Definition	Eligibility **(E1)**	Claim/Service Billing **(B1/S1)**	Information Reporting (Claim/Service) **(N1)**	Information Reporting Reversal (Claim/Service) **(N2)**
Claim	A29-ZS	Reported Adjudicated Program Type	The type of prescription benefit plan/program under which the reported claim adjudicated.		RM		
Coordination of Benefits/Other Payments	C47-9T	Other Payer Adjudicated Program Type	The type of prescription benefit plan/program associated with the Other Payer.		Q	Q	
N Transaction Payer Identification	C48-9U	N Payer Adjudicated Program Type	The type of prescription benefit plan/program under which the claim was adjudicated.			Q	Q

Additional Details for Adjudicated Program Type Request Fields:

- **REPORTED ADJUDICATED PROGRAM TYPE (A29-ZS)**
  - **Required for subrogation claims only**
  - Contains the value returned in Adjudicated Program Type (A28-ZR) of the original payer's response

- **OTHER PAYER ADJUDICATED PROGRAM TYPE (C47-9T)**
  - This field may be sent to a *downstream* payer in the COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT based on what a primary payer has returned in the ADJUDICATED PROGRAM TYPE field as part of the response transaction

- **N PAYER ADJUDICATED PROGRAM TYPE (C48-9U)**
  - This field may be sent in the N TRANSACTION PAYER IDENTIFICATION SEGMENT to report the Adjudicated Program Type of the initial payer

Transaction Responses

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The following fields are used in response transactions, and the associated values are listed under the "Adjudicated Program Type Shared Code List".

Segment	Field	Field Name	Field Definition	Eligibility **(E1)**	Claim/Service Billing **(B1/S1)**	Information Reporting (Claim/Service) **(N1)**	Information Reporting Reversal (Claim/Service) **(N2)**
Response Status	A28-ZR	Adjudicated Program Type	The type of prescription benefit plan/program under which the claim was adjudicated.	N	R	N	
Response Other Payers	C47-9T	Other Payer Adjudicated Program Type	The type of prescription benefit plan/program associated with the Other Payer.	M	M		

Additional Details for the Adjudicated Program Type Response Fields:

- **ADJUDICATED PROGRAM TYPE (A28-ZR)**
  - **Required** to be returned by a payer/processor in the RESPONSE STATUS segment on all claim/service billing transaction (B1/S1) responses.
  - The most descriptive program type value must be returned when known by the responding entity.

    Ex: The value of "Medicare" should not be returned if the responding entity knows that the prescription benefit plan under which the claim was adjudicated is a Medicare Part D PDP plan.
  - On Paid, Duplicate Paid, and Captured responses, "UNKNOWN" or "OTHER" must not be used for federal programs as defined in Section 1128B(B) of the Social Security Act.

    The value of "UNKNOWN" may be returned on a rejected response when the actual Adjudicated Program Type could not yet be determined.

- **OTHER PAYER ADJUDICATED PROGRAM TYPE (C47-9T)**
  - When the RESPONSE OTHER PAYERS SEGMENT is sent, this field is ***mandatory*** on all eligibility (E1) and claim/service billing transaction (B1/S1) responses.

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The Response Other Payers Segment is situational for an Eligibility Verification, Claim Billing, and Service Billing response when other insurance information is available and when the Header Response Status (501-F1) of "A" (Accepted) and Transaction Response Status (112-AN) of "A" (Approved) or "R" (Rejected) is returned.

- The Other Payer Adjudicated Program Type (C47-9T) may be repeated:
  - Nine times in the E1
  - Four times in the B1 and S1

Added August 2024; Updated May 2025

3.30.3 Other Coverage Information is Known

Question: How should a payer populate the Response Other Payers segment when other coverage information is known?

Answer: A payer should include information regarding other payers that will assist the pharmacy in submitting the claim to all coverages. In the scenario where the responding payer is rejecting the claim with Reject Code 41 (Submit Bill To Other Processor Or Primary Payer) because of known other coverage, the payer should populate all available information for the previous payer. The responding payer should also include any known information for additional payers.

The following shows the Response Other Payers Segment and how it may be populated to identify the primary coverage that must be submitted as well as supplemental coverage that may be available.

Excerpt from Rejected Response

RESPONSE STATUS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	M	*R*	Reject
510-FA	REJECT COUNT	R	*1*	One Occurrence
511-FB	REJECT CODE	R	*41*	Submit Bill to Other Processor or Primary Payer
C72-BH	HELP DESK SUPPORT TYPE COUNT	M	*1*	One Occurrence
C71-BG	HELP DESK SUPPORT TYPE	M	*1*	Pharmacy
C67-BB	HELP DESK BUSINESS UNIT TYPE COUNT	R	*1*	One Occurrence
C66-BA	HELP DESK BUSINESS UNIT TYPE	Q	*1*	Pharmacy Help Desk

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RESPONSE STATUS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
C70-BF	HELP DESK CONTACT INFORMATION QUALIFIER	Q	*1*	Phone Number
C68-BC	HELP DESK CONTACT INFORMATION	Q	*5558176543*	
A28-ZR	ADJUDICATED PROGRAM TYPE	R	*3*	Commercial

RESPONSE OTHER PAYERS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*28*	RESPONSE OTHER PAYERS SEGMENT
355-NT	OTHER PAYER ID COUNT	M	*3*	Three occurrences
338-5C	OTHER PAYER COVERAGE TYPE	M	*01*	Primary
D41-PQ	OTHER PAYER RELATIONSHIP TYPE	M	*CP*	COB Coverage Prior To Responding Payer
D50-P6	OTHER PAYER BENEFIT CLASSIFICATION TYPE	M	*RX*	Prescription Benefit
C47-9T	OTHER PAYER ADJUDICATED PROGRAM TYPE	M	*3*	Commercial
339-6C	OTHER PAYER ID QUALIFIER	R	*03*	BIN/IIN for first occurrence
340-7C	OTHER PAYER ID	Q	*99999900*	Primary Payer's IIN
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	Q	*ABC123*	Primary Payer's PCN
356-NU	OTHER PAYER CARDHOLDER ID	Q	*998877665*	Known ID for Cardholder for the primary payer.
338-5C	OTHER PAYER COVERAGE TYPE	M	*02*	Secondary
D41-PQ	OTHER PAYER RELATIONSHIP TYPE	M	*RP*	Responding Payer
D50-P6	OTHER PAYER BENEFIT CLASSIFICATION TYPE	M	*RX*	Prescription Benefit

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RESPONSE OTHER PAYERS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
C47-9T	OTHER PAYER ADJUDICATED PROGRAM TYPE	M	*3*	Commercial
339-6C	OTHER PAYER ID QUALIFIER	R	*03*	BIN/IIN for first occurrence
340-7C	OTHER PAYER ID	Q	*12345600*	Responding Payer's IIN
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	Q	*ZYX456*	Responding Payer's PCN
356-NU	OTHER PAYER CARDHOLDER ID	Q	*51681591069*	Responding payer's cardholder ID
992-MJ	OTHER PAYER GROUP ID	Q	*543210*	Responding Payer's Group ID
338-5C	OTHER PAYER COVERAGE TYPE	M	*03*	Tertiary
D41-PQ	OTHER PAYER RELATIONSHIP TYPE	M	*CS*	COB Coverage Subsequent To Responding Payer
D50-P6	OTHER PAYER BENEFIT CLASSIFICATION TYPE	M	*RX*	Prescription Benefit
C47-9T	OTHER PAYER ADJUDICATED PROGRAM TYPE	M	*6*	Manufacturer Sponsored Patient Pay Reduction Program
339-6C	OTHER PAYER ID QUALIFIER	R	*10*	Payer Name for subsequent coverage
340-7C	OTHER PAYER ID	Q	*XYZ MFR COPAY CARD*	Payer Name

Note:

- Responding payer information may be omitted from the Response Other Payers Segment as the pharmacy already has the information on file.
- Responding payer is aware of an existing copay assistance program for the drug being billed but does not have the specific information.

Added November 2024

3.31 Response Pricing Segment (23)

3.31.1 Regulatory Fee Exempt Indicator (D62-RM)

Question: If there is a value populated in Regulatory Fee Exempt Indicator (D62-RM), is the expectation that the payer would send a $0 amount in the Regulatory Fee Amount Paid (558-AW)?

Answer: Per the Telecommunication Standard Implementation Guide Version F6©, Section 29 Pricing Guidelines (Claim/Service), if a value greater than zero is submitted in the Regulatory Fee Amount

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Submitted (481-HA) field, then a value must be returned in the Regulatory Fee Amount Paid (558-AW) field. In the situation where a value is returned in the Regulatory Fee Exempt Indicator (D62-RM) field indicating the claim is regulatory fee exempt, zero would be returned as the Regulatory Fee Amount Paid (558-AW).

Added November 2024

3.31.2 Regulatory Fee Amount Paid (558-AW)

Question: If a value greater than $0 is returned in the Regulatory Fee Amount Paid (558-AW) and the Regulatory Fee Exempt Indicator (D62-RM) is populated, should the value in the Regulatory Fee Amount Paid (558-AW) be ignored and the Regulatory Fee Exempt Indicator (D62-RM) value take precedence?

Answer: If a value greater than zero is returned in Regulatory Fee Amount Paid (558-AW), this amount would be included in the final reimbursement as reflected in the Response Pricing Formula. Any conflict in values returned in the Regulatory Fee Amount Paid (558-AW) and Regulatory Fee Exempt Indicator (D62-RM) should be addressed through Trading Partner Agreements.

Added November 2024

3.31.3 Benefit Stage Indicator (C51-9X)

Question: Under the descriptions for Benefit Stage Indicator (C51-9X) values 50 and 51, does the term "Medicare health plans" apply to all Medicare programs that offer Part B benefits?

- Benefit Stage Indicator value 50: Paid under the Part B benefit of the Medicare health plan
- Benefit Stage Indicator value 51: Paid under the Part B benefit of the Medicare health plan for a QMB dual eligible beneficiary. Pharmacy should not attempt to collect cost-share but instead should attempt to bill COB to Medicaid coverage.

Answer: Yes, the term "Medicare health plans" apply to all Medicare programs that offer Part B benefits. The descriptions for Benefit Stage Indicator (C51-9X) values 50 and 51 are intended to apply to Managed Medicare health plans (e.g., MA (Medicare Advantage), MAPD (Medicare Advantage Prescription Drug plan)). However, when applicable, Medicare Part B Fee-for-Service (FFS) processors using NCPDP Telecommunication claims may also return these values to alert the pharmacy when an NCPDP COB claim should be submitted to the Medicaid plan, due to the Medicaid plan not supporting cross-over claims.

Added May 2025

3.31.4 Patient Pay Component Qualifier (C95-KQ)

Question: If a pharmacy receives an invalid ECL value in the Response Patient Pay Component Qualifier (C95-KQ) field, to avoid submitting the invalid value in the subsequent COB claim, should the pharmacy submit the value of 16 (*Amount Attributed to Unbalanced Patient Pay Response Received from Previous Payer*) in the corresponding Other Payer Patient Responsibility Amount (351-NP) field?

For Example:

PRIMARY CLAIM RESPONSE	**COB CLAIM REQUEST**

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VF6 FIELD ID	RESPONSE PRICING SEGMENT	vF6 VALUE
111-AM	Segment Identification	23
509-F9	Total Amount Paid	$45.25
505-F5	Patient Pay Amount	$907.00
C94-KP	Patient Pay Component Count	4
C95-KQ	Patient Pay Component Qualifier	01-Deductible
C93-KN	Patient Pay Component Amount	$895.00
C95-KQ	Patient Pay Component Qualifier	05-Copay
C93-KN	Patient Pay Component Amount	$10.00
C95-KQ	Patient Pay Component Qualifier	71 - INVALID VALUE
C93-KN	Patient Pay Component Amount	$2.00
C95-KQ	Patient Pay Component Qualifier	03-Percent Tax
C93-KN	Patient Pay Component Amount	$0.00

vF6 Field ID	vF6 Field Name	vF6 Value
353-NR	Other Payer-Patient Responsibility Amount Count	4
351-NP	Other Payer-Patient Responsibility Amount Qualifier	01-Deductible
352-NQ	Other Payer-Patient Responsibility Amount	$895.00
351-NP	Other Payer-Patient Responsibility Amount Qualifier	05-Copay
352-NQ	Other Payer-Patient Responsibility Amount	$10.00
351-NP	Other Payer-Patient Responsibility Amount Qualifier	16 - Amount Attributed to Unbalanced Patient Pay Response Received from Previous Payer
352-NQ	Other Payer-Patient Responsibility Amount	$2.00
351-NP	Other Payer-Patient Responsibility Amount Qualifier	03-Percent Tax
352-NQ	Other Payer-Patient Responsibility Amount	$0.00

Answer: Yes, it is recommended to submit the amount related to the invalid Patient Pay Component Qualifier (C95-KQ) using the Other Payer-Patient Responsibility Amount Qualifier (351-NP) value 16 (Amount Attributed to Unbalanced Patient Pay Response Received from Previous Payer). All the valid Patient Pay Component Qualifiers and Amounts map directly to the OPPRA Qualifiers and Amounts. Any

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amount(s) associated to invalid Patient Pay Component Qualifier (C95-KQ) cannot be mapped directly to the OPPRA COB transaction because the OPPRA qualifier value does not exist.

Value 16 was added to allow pharmacies to pass through the unbalanced amount between Patient Pay (505-F5) and the sum of the Patient Pay Component Amounts (C93-KN). Although the Patient Pay Component Amounts in the above example sum to the Patient Pay Amount, the pharmacy needs a way to pass through the amount related to an invalid qualifier. This creates the same situation as an unbalanced amount, therefore the recommendation is to use the Other Payer-Patient Responsibility Amount Qualifier (351-NP) value 16.

Added June 2026

3.32 Response DUR/PPS Segment (24)

3.32.1 DUR/DUE Free Text Message (544-FY)

Question: For the Response DUR/PPS Segment on a Claim Billing or Encounter transaction (B1), is the field DUR/DUE Free Text Message (544-FY) allowed to be sent without a Reason For Service Code (439-E4) or any other associated fields in the initial loop of a DUR/PPS Response?"

Answer: No, the DUR/DUE Free Text Message (544-FY) must be sent with a Reason for Service Code (439-E4). Refer to the NCPDP Telecommunication Standard Version F6© which lists the Reason for Service Code (439-E4) as a required field in the Response DUR/PPS Segment if a utilization conflict is detected.

Added August 2025

Question: Does the DUR/DUE Free Text Message (544-FY) field allow for 9 repetitions of 360 bytes each, or is it 9 repetitions for 360 bytes total?

Answer: In the NCPDP Telecommunication Standard Version F6©, the DUR/DUE Free Text Message (544-FY) field is a component of a logical grouping which supports up to nine repetitions. Within each of these repetitions, 544-FY allows up to 360 bytes of messaging. This structure is designed to accommodate multiple Drug Utilization Review (DUR) occurrences within a single claim response.

In total, this could theoretically result in up to 3,240 bytes of free text messaging if all nine repetitions are utilized at their maximum length. While this capacity allows for detailed messaging, it also introduces potential challenges for processors, pharmacy systems, and downstream entities in terms of data storage, display, and user accessibility. Some pharmacy systems may truncate messages, require additional navigation to view full content, or may not display all messages in a user-friendly manner.

To improve clarity and streamline processing, processors are encouraged to minimize the use of free-text messaging whenever possible. Instead, processors should utilize the new structured fields available within the DUR/PPS Response Segment in the Telecommunication Standard Version F6©, which clearly organizes alert information, making it easier for pharmacy systems and staff to quickly understand and act on the data. These fields include, but are not limited to:

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- DUR/DUE Co-Agent ID Qualifier (475-J9)
- DUR/DUE Co-Agent ID (476-H6)
- DUR/DUE Co-Agent Description (E93-ZC)
- Other Prescriber & Pharmacy Information (various fields)
- Minimum/Maximum Limitations (various fields)

Additionally, it is recommended that processors optimize and streamline DUR messaging to ensure clarity and usability. Specifically, refer to Section *27.1.8.2.1, "The Problem of Noise"* in the NCPDP Telecommunication Standard VF6©, which provides best practices for maintaining relevant and concise messaging.

Key recommendations include:
- Prioritize and return the **most clinically significant alerts** in order of importance.
- **Minimize duplication** of DUR alerts.
- **Reduce false positives** where possible.

Ensure that free text messages are **clear, concise, and easily interpretable**, avoiding overly cryptic language.

Added December 2025

3.32.2 DUR Alerts

Question: How can a payer communicate to a pharmacy that more than 9 DUR alerts apply to a claim, what should be considered and how can the pharmacy resolve the alerts?

Answer: Per the Telecommunication Standard VF6©, "If more than nine Reasons for Service occur, it is recommended the ninth repetition of the Reason for Service Code (439-E4) and all repeating fields that follow be used to notify the provider to Call Help Desk ("CH")."

Considerations:

Payers should consider the following to ensure simplicity and timely patient access to care:

- Select the most appropriate Reject Code (511-FB) based on the availability of an override at point-of-sale.
  - Overridable at POS
    - DO5 – DUR Conflict. Limited override allowed at pharmacy. Thereafter, a prior authorization may be required
    - 88 – DUR Reject Error
  - Not Overridable at POS. PA Required
    - 943 – DUR Reject - Pharmacy Override Using DUR/PPS Not Allowed
    - 75 – *Prior Authorization Required*, in lieu of a DUR-related Reject Code (511-FB) value
      Note: Reject code 943 may also be returned with the relevant Reason for Service Code values as additional information that can be provided to the prescriber when completing the prior authorization.
- Reason for Service Code (439-E4) values should be returned in rank order based on the Clinical Significance Code (528-FS) with the highest clinical significance being returned first.

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- Payers may opt to avoid using Reason for Service Code (439-E4) value CH – *Call Help Desk* by:
  - Limiting their systems to return no more than 9 DUR alerts, particularly if alerts beyond the 9th are of low clinical significance.
  - Returning the first 9 Reason for Service codes for resolution, then returning additional Reason for Service codes on subsequent claim attempts (assuming prior codes were resolved) until all Reason for Service codes have been resolved. *Note: it is recommended that only high clinical significance codes be returned if this option is leveraged.*
- Review relevant sections of the Telecommunication Standard Version F6©
  - Section 27.1.8.2 "*The Problem of Noise*" for additional information on effective communication of DUR alerts, which indicates a multitude of ways to reduce the number of alerts, thereby reducing the likelihood of more than nine DUR alerts being applicable.
  - Section 6.26 Coverage of a Duplicate Therapy Interaction

Resolving Reject Code (511-FB) values DO5 or 88 when Reason for Service Code (439-E4) value CH is also returned

When the pharmacy receives Reason for Service Code (439-E4) value CH – *Call Help Desk*, the pharmacy should call the payer/processor help desk to identify the remaining Reason for Service Codes and descriptions. Using this information, the pharmacist can determine how best to address all DUR alerts applicable to the claim. If the pharmacist determines that dispensing the product is appropriate, the payer/processor help desk will communicate how to resolve the DUR conflict at POS. *Note: How the payer arrives at this decision is up to their own internal processes but should be looking at all the alerts/factors to arrive at that decision. Override of the DUR rejection does not require the payer to return a paid response, other rejections may still apply.* These could include:

- Payer-side resolution: After discussion with the Pharmacist, the Payer Help Desk may apply a POS override, allowing the claim to pass the DUR validation step. The pharmacy would then need to resubmit the claim.

- Pharmacy-side resolution: After discussion with the Pharmacist, the Payer Help Desk may provide an authorization number to the Pharmacist, allowing the claim to pass the DUR validation step. The pharmacy would need to resubmit the claim with this authorization number in the Prior Authorization ID Submitted (462-EV) field.

The pharmacy should not be required to override the Reason for Service Code (439-E4) value CH – *Call Help Desk*. This value is an administrative code and is used to communicate that additional Reason for Service Code values apply. However, the payer or processor should not reject a subsequent claim submission solely because it includes or omits Reason for Service Code CH and/or the associated Professional Service Code and Result of Service code.

Added December 2025

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3.33 Response Prior Authorization Segment (26)

3.34 Response Intermediary Segment (36)

3.35 Response Other Related Benefit Detail Segment (39)

3.36 Response Provider Segment (40)

5

3.37 Coordination of Benefits Information

3.37.1 Other Payer Amount Paid Qualifiers (342-HC) For S1 (Service Billing) COB

Question: How should the pharmacy populate the Other Payer Amount Paid (431-DV) field for Other Payer Amount Paid Qualifier (342-HC) value = 06 – Cognitive/Professional Service for the S1 transaction?

Answer: There is no direct mapping from an S1 response pricing field to report the Other Payer Amount Paid Qualifier (342-HC) value of 06 - Cognitive/Professional Service. The Other Payer Amount Paid (431-DV) price for Cognitive/Professional Service is a calculated amount, similar to how Drug Benefit is calculated for a COB B1 claim request.

To accurately report the amounts paid in the Other Payer Amount Paid field (431-DV) in a COB Other Payer Coverage Type occurrence for S1 service billing, a specific order of Other Payer Amount Paid Qualifiers (342-HC) must be followed.

- Order is based on the payment being associated to provider versus state revenue, the professional service (e.g., cognitive service) and any value-added services (i.e., delivery, administrative).
- Cognitive/Professional Service (Other Payer Amount Paid Qualifier (342-HC) value 06) is the end result, after all Other Payer Amount Paid values are subtracted from Total Amount Paid (509-F9).
- Note: The following Other Payer Amount Paid Qualifier (342-HC) values are not applicable to S1 COB billing, as the associated response pricing fields are not used in the S1 transaction, and 07-Drug Benefit is a calculated amount specific to B1 claim billing transaction.
    - 02: Shipping
    - 03: Postage
    - 05: Incentive
    - 07: Drug Benefit

OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) VALUE 06 = COGNITIVE/PROFESSIONAL SERVICE CALCULATION

Total Amount Paid (509-F9)

- Percentage Tax Amount Paid (559-AX)
- Regulatory Fee Amount Paid (558-AW)
- Other Amount Paid (565-J4), Other Amount Paid Qualifier (564-J3) value 01 = Delivery Cost
- Other Amount Paid (565-J4), Other Amount Paid Qualifier (564-J3) value 04 = Administrative Cost

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= Cognitive/Professional Service

The following table reflects the specific vF6 fields from the prior payer claim response that would be used to populate the applicable Other Payer Amount Paid Qualifier (342-HC) values in the vF6 S1 COB service billing request transaction.

vF6 S1 Response Field	vF6 S1 Response Field Qualifier	vF6 S1 COB Request Other Payer Amount Paid Qualifier (342-HC) value reported with the associated Other Payer Amount Paid (341-DV) dollar amount
509-F9 Total Amount Paid		
- (559-AX Percentage Tax Amount Paid – C93-KN Patient Pay Component Amount)	C95-KQ Patient Pay Component Qualifier (03) Percentage Tax	342-HC OPAP Qualifier = (15) Percentage Tax
- (558-AW Regulatory Fee Amount Paid – C93-KN Patient Pay Component Amount)	C95-KQ Patient Pay Component Qualifier (17) Regulatory Fee	342-HC OPAP Qualifier = (12) Regulatory Fee
- 565-J4 Other Amount Paid	564-J3 Other Amount Paid Qualifier (01) Delivery Cost	342-HC OPAP Qualifier = (01) Delivery Cost
- 565-J4 Other Amount Paid	564-J3 Other Amount Paid Qualifier (04) Administrative Cost	342-HC OPAP Qualifier = (04) Administrative Cost
= Cognitive Service		342-HC OPAP Qualifier = (06) Cognitive/Professional Service

Added August 2025

3.37.2 Payer-to-Payer COB

Question: What is payer-to-payer coordination of benefits?

Answer: Payer-to-payer coordination of benefits is described in the NCPDP Telecommunication Standard© Section 3.2.2 as the two-way communication between adjudicators. There are two examples of payer-to-payer scenarios mentioned:

- Medicare Crossover – Medicare crossover process does not utilize NCPDP transactions to bill downstream payers.
- Information Reporting Transactions – Information Reporting is an NCPDP-defined transaction that may be payer-to-payer.

Other examples of payer-to-payer coordination of benefits include:

- Subrogation, a process with its own implementation guide using the NCPDP Telecommunication Standard© detail transaction and the NCPDP Batch Standard©
- Financial information reporting, a process with its own implementation guide, NCPDP Financial Information Reporting Standard©

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Added December 2025

3.37.3 IIN/PCN Combination

Question: Can an IIN/PCN combination contain groups that use multiple COB methods?

Answer: While there is nothing specific in guidance that precludes multiple COB methods within the same IIN/PCN combination, NCPDP recommends there only be one COB method used for any IIN/PCN combination. As new business is added, it is recommended PBM/payers assign them to a unique IIN/PCN combination that uses the desired COB method. Payers are encouraged to migrate existing groups to an IIN/PCN combination that solely supports the COB method, if possible.

Added September 2026

3.38 Insulin Administration – Delivery Device

Question: What claim billing data elements can be used to communicate the delivery device method for rapid-acting insulin claims and assist in determining the appropriate Medicare benefit under which the claim should adjudicate?

Answer: The External Code List© (ECL) values below have been created for use with existing ECL values to support a standardized point of service process to communicate insulin delivery device method information when necessary.

Reason for Service Code (439-E4):

One new Reason for Service Code (439-E4) has been created for the payer to return on a rejected response, indicating the insulin delivery device method is needed.

- MD - Medication Delivery Device Method Required
  Code indicating that a payer/processor requested information related to the delivery device method of the dispensed drug
  Value Limitation: Not Used in Real Time Prescription Benefit Standard

Professional Service Code (440-E5):

One new Professional Service Code (440-E5) value has been created to support emergency situations when the insulin delivery device method cannot be confirmed.

- UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access
  Code indicating the delay to confirm the medication delivery device method would compromise patient therapy.

Note, there are other existing Professional Service Code (440-E5) values that can be used for the pharmacy to indicate the source of the insulin delivery method information.

Result of Service Code (441-E6):

Three new Result of Service Code (441-E6) values have been created for the pharmacy to communicate the insulin delivery device method of the dispensed insulin product.

- 5A – DME Pump Delivery Device Method
  Dispensed drug is being administered via durable medical equipment (DME) pump. DME is defined by Medicare as medically necessary, reusable medical equipment
- 5B - Non-DME or Disposable Delivery Device Method

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Dispensed drug is being administered via non-durable medical equipment (DME) pump or some other disposable mechanism. Examples of these products may include disposable pumps, pens, needles/syringes.

- 5C – Unknown Delivery Device Method and Immediate Access Required
  Medication delivery device method of dispensed drug is unknown, not defined on the prescription. Patient requires immediate access to medication.

Approved Message Code (548-6F):
One new Approved Message Code (548-6F) value has been created for the payer to communicate on a Paid claim response when the Result of Service Code value for Unknown Delivery Device Method and Immediate Access Required has been accepted under an exception.

- 062 - Submitted claim indicates Unknown Delivery Device Method; may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills.

Pharmacies could pro-actively submit an applicable Result of Service Code (441-E6) value to identify the insulin delivery device method, as the information may be mapped from an e-prescription to the B1 claim request. Refer to the SCRIPT Implementation Recommendations document for more information about how prescribers can communicate the insulin delivery device method information on an eRX using the current and future versions of the SCRIPT Standard.

If the information is not on the submitted claim and is necessary for the payer to complete the claim adjudication process, payers can initiate the point of service communication process using the specified ECL values as outlined below.

Refer to the Insulin Delivery Device Method DUR Code Set Sample Matrices at the end of this FAQ for a combination of Reason for Service (439-E4), Professional Service (440-E5) and Result of Service Code (441-E6) code values that could be submitted on the request.

POINT OF SERVICE CLAIMS PROCESSING GUIDANCE BASED ON MEDICARE PLAN TYPE

PDP - Prescription Drug Plan (Part D Benefit ONLY, No Part B)

1. Rapid-acting insulin claim submitted
2. If Patient Residence Code = 3 (Nursing Facility) or 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities), regardless of the insulin delivery device method, claim continues to adjudicate under the PDP benefit.
3. All other Patient Residence Codes, or Patient Residence Code not submitted, and the Result of Service Code (441-E6) field does not contain one of the new insulin delivery device method values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*
   ii. Reason For Service Code (439-E4): MD - *Medication Delivery Device Method Required*
   iii. Additional Message Information (526-FQ) indicating claim should be submitted with an appropriate Result of Service Code (441-E6) value to identify the insulin delivery device method

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4. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of MD – *Medication Delivery Device Method Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
    i. 5A - *DME Pump Delivery Device Method*
        - Payer Response: Claim rejects with Reject Code (511-FB): A6 – *This Product/Service May Be Covered Under Medicare Part B*
    ii. 5B- *Non-DME or Disposable Delivery Device Method*
        - Payer Response: Claim continues to adjudicate under the PDP benefit
    iii. 5C - *Unknown Delivery Device Method and Immediate Access Required*
        - Payer Response: Claim continues to adjudicate under the PDP benefit
            - If final status is a Paid claim, plan to return Approved Message *Code* (548-6F) *062 - Submitted claim indicates Unknown Delivery Device Method; may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills*
5. If required, Pharmacy includes one of the below Professional Service Code (440-E5) values:
    i. M0 - Prescriber consulted
    Communication with prescriber related to collection of information or clarification of a drug therapy concern
    ii. P0 - Patient consulted
    Consultation with the patient to clarify or collect additional information
    iii. R0 - Pharmacist consulted other source
    Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern
    iv. UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access
    Code indicating the delay to confirm the medication delivery device method would compromise patient therapy

MA Only - Medicare Advantage (Part B Benefit ONLY, No Part D)

1. Rapid-acting insulin claim submitted
2. If Patient Residence Code = 3 (Nursing Facility) or 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities), regardless of the insulin delivery device method, claim rejects with Reject Code (511-FB) value 620 – *This Product/Service May Be Covered Under Medicare Part D*
3. All other Patient Residence Codes, or Patient Residence Code not submitted, and the Result of Service Code (441-E6) field does not contain one of the new insulin delivery device method values, the claim may reject as follows:
    i. Reject Code (511-FB): 88 – *DUR Reject Error*
    ii. Reason For Service Code (439-E4): MD - *Medication Delivery Device Method Required*

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iii. Additional Message Information (526-FQ) indicating claim should be submitted with an appropriate Result of Service Code (441-E6) value to identify the insulin delivery device method.

4. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of MD – *Medication Delivery Device Method Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
   i. 5A - *DME Pump Delivery Device Method*
      - Payer Response: Claim continues to adjudicate under the MA Only benefit
   ii. 5B - *Non-DME or Disposable Delivery Device Method*
      - Payer response: Claim rejects with Reject Code (511-FB): 620 – *This Product/Service May Be Covered Under Medicare Part D*
   iii. 5C - *Unknown Delivery Device Method and Immediate Access Required*
      - Payer Response: Claim continues to adjudicate under the MA Only benefit
        - If final status is a Paid claim, plan to return Approved Message Code (548-6F): 062 - *Submitted claim indicates Unknown Delivery Device Method; may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills.*
5. If required, Pharmacy includes one of the below Professional Service Code (440-E5) values:
   i. M0 - Prescriber consulted
   Communication with prescriber related to collection of information or clarification of a drug therapy concern
   ii. P0 - Patient consulted
   Consultation with the patient to clarify or collect additional information
   iii. R0 - Pharmacist consulted other source
   Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern
   iv. UA- Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access.
   Code indicating the delay to confirm the medication delivery device method would compromise patient therapy

MAPD – Medicare Advantage Prescription Drug (Part B+D BENEFITS)

1. Rapid-acting insulin claim submitted
2. If Patient Residence Code = 3 (Nursing Facility) or 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities), the claim should continue to adjudicate under the Part D benefit regardless of the insulin delivery device method
3. All other Patient Residence Codes, or Patient Residence Code not submitted, and the Result of Service Code (441-E6) field does not contain one of the new insulin delivery device method values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*

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ii. Reason For Service Code (439-E4): MD - *Medication Delivery Device Method Required*
iii. Additional Message Information (526-FQ) indicating claim should be submitted with an appropriate Result of Service Code (441-E6) value to identify the insulin delivery device method.

4. Pharmacy resubmits claim with one of the below Result of Service Code values:
   i. 5A - *DME Pump Delivery Device Method*
      - Payer Response: Claim continues to adjudicate under the MAPD Part B benefit
   ii. 5B - *Non-DME or Disposable Delivery Device Method*
      - Payer Response: Claim continues to adjudicate under the MAPD Part D benefit
   iii. 5C - *Unknown Delivery Device Method and Immediate Access Required*
      - Claim routed to applicable plan benefit based on plan setup
        - If final status is a Paid claim, plan to return Approved Message Code 062 - *Submitted claim indicates Unknown Delivery Device Method; may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills.*
5. If required, Pharmacy resubmits claim with one of the below Professional Service Code (440-E5) values:
   i. M0 - Prescriber consulted
   Communication with prescriber related to collection of information or clarification of a drug therapy concern
   ii. P0 - Patient consulted
   Consultation with the patient to clarify or collect additional information
   iii. R0 - Pharmacist consulted other source
   Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern
   iv. UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access
   Code indicating the delay to confirm the medication delivery device method would compromise patient therapy

Insulin Delivery Device Method DUR Code Set Sample Claim Request Matrices

Scenario	Request: Reason for Service Code (439-E4)	Professional Service Code (440-E5)	Result of Service Code (441-E6)
Pharmacy Proactively Submits Medication Delivery Device Method	–	M0 - Prescriber Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method

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Pharmacy Proactively Submits Medication Delivery Device Method	–	P0 - Patient Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Pharmacy Proactively Submits Medication Delivery Device Method	–	R0 - Pharmacist Consulted Other Source	5A - DME Pump Delivery Device Method, or 5B- Non-DME or Disposable Delivery Device Method
Pharmacy Proactively Submits Medication Delivery Device Method	–	UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access	5C - Unknown Delivery Device Method and Immediate Access Required
Pharmacy Proactively Submits Medication Delivery Device Method	MD - Medication Delivery Device Method Required	M0 - Prescriber Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Pharmacy Proactively Submits Medication Delivery Device Method	MD - Medication Delivery Device Method Required	P0 - Patient Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Pharmacy Proactively Submits Medication Delivery Device Method	MD- Medication Delivery Device Method Required	R0 - Pharmacist Consulted Other Source	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Pharmacy Proactively Submits Medication Delivery Device Method	MD - Medication Delivery Device Method Required	UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access	5C - Unknown Delivery Device Method and Immediate Access Required
Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required	MD - Medication Delivery Device Method Required	M0 - Prescriber Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required	MD - Medication Delivery Device Method Required	P0 - Patient Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method

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Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required	MD - Medication Delivery Device Method Required	R0 - Pharmacist Consulted Other Source	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required	MD - Medication Delivery Device Method Required	UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access	5C - Unknown Delivery Device Method and Immediate Access Required

Added August 2024

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4. BEST PRACTICES SECTION

4.1. COB Section

4.1.1. Patient Pay Component Qualifier when Patient Pay Amount is Zero

Question: Because the Patient Pay Component fields are required in a paid response transaction, when the Patient Pay Amount (505-F5) being returned is zero what Patient Pay Component Qualifier (C95-KQ) should be sent?

Answer: In the situation where the Patient Pay Amount (505-F5) being returned is zero, the payer/processor should return the Patient Pay Component Qualifiers (C95-KQ) that best reflect the plan benefit design. For example, if the standard benefit utilizes copay, then the Patient Pay Component Qualifier (C95-KQ) returned in the response transaction should be '05 – Amount of Copay'. If the plan design contains multiple components, the payer may return all applicable component qualifiers. See examples below:

Plan Benefit Design	Patient Pay Component Qualifier Values	Patient Pay Component Amount (Sum of components = 0)
Flat Copay	05 – Amount of Copay	$0.00
Percentage Coinsurance	07 – Amount of Coinsurance	$0.00
Deductible Plus Coinsurance	01 – Amount Applied to Periodic Deductible 07 – Amount of Coinsurance	$0.00 $0.00
Deductible Plus Coinsurance Plus Health Plan Funded Assistance – Health Reimbursement Account (HRA)	01 – Amount Applied to Periodic Deductible 07 – Amount of Coinsurance 09 – Amount Attributed to Health Plan Assistance Amount	$50.00 $22.21 -$72.21

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5. GENERAL SECTION

5.1 Dollar Amounts

Question: Does a payer/processor have to accept a dollar amount up to $999,999,999.99?

Answer: A receiver must be able to accept field values up to the limit defined by the standard. Significant digits of submitted values should not be truncated; see section 7.7.3 and section 7.7.3.1 of the Telecommunication Implementation Guide. If the processor cannot support a dollar amount up to the defined limit, the processor should reject the claim with reject code 945 - High Dollar Amount Is Not Supported. Additionally, the processor should return a message to the pharmacy identifying the field in error and provide further guidance to the pharmacy of alternate methods of submitting the claim.

5.2 HIPAA Compliance

Question: After the HIPAA mandated Telecommunication Standard Version F6© compliance date of 4/14/2028, can a processor respond to a D.0 request with an F6 response?

Answer: No, responding to a transaction in a different version is NOT allowed per Section 27.2.1 of the Telecommunication Standard Version F6© Implementation Guide - "The Response Header Segment contains the field Version/Release Number, Transaction Code, Transaction Count, Service Provider ID Qualifier, Service Provider ID, and Date of Service that are also used in the Transaction Header Segment. The intent of these fields within the Response Header Segment is to echo without change, the values submitted."

Question: A claim (B1) in the Version D.0 format was submitted and paid on 4/1/2028. On 4/15/2028 the claim needs to be reversed. Should the reversal be submitted in the Version D.0 format (original claim) or Version F6 format (mandated HIPAA format)?

Answer: The reversal transaction must be submitted in the Version F6 format per the *Administrative Simplification: Modifications of Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Standards; and Modification of the Medicaid Pharmacy Subrogation Standard* Final Rule. The Reconciliation ID (B98-34) is a required field on a Version F6 reversal transaction and would contain "NOTAVAILABLE".

Added March 2026

5.3 Claim Submission Entities

Question: What types of entities may submit claims using NCPDP Telecommunication Standard© transactions? Must the submitter be a pharmacy?

Answer: The NCPDP Telecommunication Standard© does not restrict submission solely to pharmacies or pharmacists. Any entity acting as the service provider may submit transactions as long as*:*

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i. The entity can be properly identified using the Service Provider ID Qualifier (202-B2) and Service Provider ID (201-B1) fields,
ii. The transaction is permitted under applicable laws, regulations, and contractual or payer requirements, and
iii. The payer accepts NCPDP Telecommunication Standard© transactions for that type of product/service.

This may include pharmacies, physicians, clinics, or other qualified providers when allowed by regulation and payer policy.

Added March 2026

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6. BATCH STANDARD SUBROGATION IMPLEMENTATION GUIDE

6.1 Cardholder ID (302-C2) and Medicaid ID Number (115N5) use in Subrogation

Question: How are Cardholder ID (302-C2) and Medicaid ID Number (115-N5) used within the Batch Standard Subrogation detail transaction?

Answer: Medicaid ID Number (115-N5) is only used when Medicaid is the original adjudicator seeking subrogation per section 4.1.1 of the *Batch Standard Subrogation Implementation Guide*. In the Request Insurance Segment, the Medicaid ID Number (115-N5) contains the member's ID used by Medicaid while the Cardholder ID (302-C2) represents the member's ID for the additional adjudicator.

In the Response Insurance Segment for Medicaid Subrogation claims, the Medicaid ID Number (115-N5) echoes the value submitted on the request. The Cardholder ID (302-C2) is situational, and when returned, the Cardholder ID (302-C2) would reflect the ID used by the additional adjudicator.

Added November 2023

6.2 When is Medicaid Agency Number (116-N6) used in Subrogation

Question: When is Medicaid Agency Number (116-N6) used in Batch Standard Subrogation transactions?

Answer: Medicaid Agency Number (116-N6) is only used when Medicaid is the original adjudicator seeking subrogation per section 4.1.1 of the *Batch Standard Subrogation Implementation Guide*. In the Request Insurance Segment, the Medicaid Agency Number (116-N6) is used to report the Medicaid Agency Number as known to the additional adjudicator. In the Response Insurance Segment for Medicaid Subrogation claims, the Medicaid Agency Number (116-N6) echoes the value submitted on the request.

Medicaid Agency Number (116-N6) would not be used in any situation where Medicaid is not the original adjudicator.

Added November 2023

6.3 Reported Adjudicated Program Type

Question: How is Reported Adjudicated Program Type (A29-ZS) used in subrogation?

Answer: Reported Adjudicated Program Type (A29-ZS) is used by the original adjudicator to report their Adjudicated Program Type (A28-ZR). It is a required field for subrogation as indicated by the "RM" designation in the *NCPDP Telecommunication Standard Version F6©.*The original adjudicator should select the most specific ECL value that reflects the type of program the claim adjudicated under. For example, a Children's Health Insurance Program (CHIP) should use the applicable value for Children's Health Insurance Program (CHIP) rather than the value for Medicaid, which is a more general program.

Added December 2025

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APPENDIX A – MODIFICATIONS TO THIS DOCUMENT

Version 01

Original Version

Version 02

- Created a HIPAA Compliance Section and added two questions/answers
- Created a Claim Submission Entities Section and added a question/answer
- Added a question on Other Payer Percentage Tax Exempt Indicator (D51-P7) and Other Payer Regulatory Fee Exempt Indicator (D52-P8)
- Added a question on Other Payer Amount Paid (OPAP) occurrences
- Added an Editorial Correction for Section 28.3.3.2, Section 35.23, Section 26.3.5.1.2 and Section 28.2 in the Telecommunication Standard Version F6 Implementation Guide©

Version 03

- Added a Submission Clarification Code Question
- Updated the No Prescriber Prescription Question
- Added a Prescriber DEA Number Question
- Added a Patient Pay Component Qualifier Question
- Updated Appendix B – Question 1
- Updated Route of Administration (995-E2) and SNOMED CT Codes in the Request Claim Segment Section
- Added a Duplicate DUR Request Segment Question

Version 04

- Added IIN/PCN Combination Use in Multiple COB Methods Question
- Added Prescriber DEA Number Question
- Added Combined Response from Two Separate Payers Question
- Added a Place of Service Question
- Added a Total Prescribed Quantity Remaining Question
- Added a Section on Prescriber ID Rejection Questions

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APPENDIX B – ROUTE OF ADMINISTRATION QUESTIONS

BEST PRACTICES FOR USE OF SNOMED CT ROUTE OF ADMINISTRATION VALUES

1. **Question:** Which "edition" of SNOMED CT Route of Administration data should be used and where can it be located?

   Answer: The Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) United States (US) Edition is the official source of SNOMED CT for use in US healthcare systems, as referenced by United States Core Data for Interoperability (USCDI) and the Interoperability Standards Advisory (ISA).

   The National Library of Medicine (NLM) distributes the US Edition of SNOMED CT, which is a standalone release that combines the content of both the US Extension and the International releases of SNOMED CT.

   The SNOMED CT Route of Administration subset is publicly available on the NLM Value Set Authority Center (VSAC) web site *Value Set Authority Center (nih.gov)*.

   NCPDP's External Code List© (ECL) entry for Route of Administration (995-E2) points to NLM's VSAC for the list of values and includes a link with instructions for how to download the data. These instructions can also be found here.

   To ensure consistent values and processes across trading partners, NCPDP recommends using the downloadable list of codes published by NLM.

   NLM has a website which addresses some frequently asked questions:
   http://www.nlm.nih.gov/research/umls/Snomed/snomed_faq.htm

   Updated June 2026

2. **Question**: If a SNOMED CT Route of Administration code is listed on the NLM VSAC site, a payer/processor choose to not support the code and reject the claim?

   Answer: NCPDP does not dictate business requirements. If their business warrants it, the payer/processor may choose to not cover or support a code and deny a claim with Reject Code (511-FB) values such as 552 (Route of Administration Value Not Supported), 9Q (Route of Administration Submitted Not Covered) or other applicable values.

   However, Reject Code value E2 (M/I Route of Administration) should not be used to communicate that the code is not supported or covered.

3. **Question:** If a processor does not recognize a value being submitted in Route of Administration (995-E2) because they are using a different version of NLM's SNOMED CT ROA subset than the pharmacy, what is the appropriate reject code?

   Answer: When an unrecognized value is submitted in field Route of Administration (995-E2) and the processor is requiring the field data, the reject code E2 (M/I Route of Administration) should be used.

   To minimize the potential for unrecognized values due to trading partners referencing different versions of the published SNOMED CT Route of Administration codes, it is recommended that all industry participants regularly update their internal databases with the biannually published list from NLM.

   Note: Please reference FAQ #2 above.

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TIMING CONSIDERATIONS

1. **Question:** How should the industry support the changes within the SNOMED CT vocabulary which occurs outside the NCPDP ECL timelines?
   Answer: The NCPDP External Code List© timelines were developed and approved by the NCPDP membership for values that occur **within** the NCPDP External Code List© publications. The vocabulary owners (FDA for NDC, HHS for ICD, NLM for SNOMED, NCI for FMT DoseForm, etc.) are based on the schedule established by these entities for their products. As the industry implements, for example NDC or ICD-9 updates outside of the NCPDP External Code List© timeline, implementation of SNOMED is based on NLM's publication dates.

2. **Question:** How often is a version of SNOMED released?
   Answer: The US Edition of SNOMED CT is released bi-annually in the months of March and September. Trading partners should make every effort to ensure the latest code sets have been downloaded and integrated into their systems.

   Trading partners are strongly encouraged to not use retired and/or ambiguous codes that are not valid Route of Administration codes per SNOMED CT guidance.

   As stated in the Quick Reference Chart in the *NCPDP Use of External Code Lists© and Vocabularies* for code set updates that do not require immediate use, it is recommended external code set updates be implemented within 180 days of their publication.

ROUTE OF ADMINISTRATION IN THE NCPDP TELECOMMUNICATION STANDARD

1. **Question:** Is Route of Administration (995-E2) required in NCPDP transactions?
   Answer: No. The Route of Administration (995-E2) is not mandatory or required in NCPDP transactions. The field is situational. Entities that wish to receive the field are to denote the situation when the field is required. The submission of Route of Administration (995-E2) in transactions helps to further clarify the compound being submitted or to override a default route referenced for the product.

2. **Question:** In the Telecommunication Standards lower than Version F8, the field length for Route of Administration (995-E2) is 11 characters, however some values within the SNOMED CT Route of Administration Code set are greater than 11 characters. Is there guidance on how to transmit and process values greater than 11 characters in the Telecommunication Standards lower than Version F8?
   Answer: We recommend using the first 11 digits and truncating the remaining digits as applicable. This recommendation is based on the February 2022 analysis of the code set which indicates truncation would not create duplicates. In Versions F8 and greater, the field length is 20 characters.

Entire Appendix Added August 2024

APPENDIX C – MEDICARE PART D TOPICS

Hepatitis B Vaccine Billing

Question: Hepatitis B vaccine can be covered under either Medicare Part B or Part D depending on the patient's risk of contracting the infection. What information should the pharmacy submit on the claim to allow the payer to make the payment determination?

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Answer: The new External Code List (ECL) values below have been created for use with existing ECL values to support a standardized point of service process to communicate whether the patient is at low risk or moderate to high risk of becoming infected with the hepatitis B virus to determine Medicare Part B or Part D coverage.

Reason for Service Code (439-E4):
One new Reason for Service Code (439-E4) value has been created for the payer to return on a rejected response, indicating more information is needed to complete vaccine billing.

- UE – Hepatitis B Risk Determination Required
  Code indicating that risk of contracting Hepatitis B is needed to determine Medicare Part B or Medicare Part D coverage for Hepatitis B vaccination.

Result of Service Code (441-E6):

Three new Result of Service Code (441-E6) values have been created for the pharmacy to communicate the patient's risk of contracting the hepatitis B virus.

- 5D – Low Risk of Hepatitis B
  Low risk of contracting hepatitis B as defined by CMS guidelines.
- 5E – Medium/High Risk of Hepatitis B
  Medium to high risk of contracting Hepatitis B includes vaccine status unknown by patient, no prior vaccination, and/or other risk factors as defined by CMS guidelines.
- 5H - Unknown Exposure/Risk
  Exposure or risk to determine vaccine coverage is unknown to pharmacy.

Pharmacies could proactively submit an applicable Result of Service Code (441-E6) value to identify the patient's risk of contracting the hepatitis B virus.

If the information is not on the submitted claim and is necessary for the payer to complete the claim adjudication process, payers can initiate the point of service communication process using the specified ECL values as outlined below.

Refer to the Vaccine Billing DUR Code Set Sample Matrices at the end of this FAQ for a combination of Reason for Service (439-E4) and Result of Service Code (441-E6) code values that could be submitted on the request.

POINT OF SERVICE CLAIMS PROCESSING GUIDANCE BASED ON MEDICARE PLAN TYPE
PDP - Prescription Drug Plan (Part D Benefit ONLY, No Part B) for Hepatitis B Vaccine

1. Hepatitis B vaccine claim submitted
2. If the Result of Service Code (441-E6) field does not contain one of the new risk values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*
   ii. Reason For Service Code (439-E4): UE - *Hepatitis B Risk Determination Required*
3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of EU – *Hepatitis B Risk Determination Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
   i. 5D – Low Risk of Hepatitis B
      - Payer Response: Claim continues to adjudicate under the PDP benefit
   ii. 5E – *Medium/High Risk of Hepatitis B*
      - Payer Response: Claim rejects with Reject Code (511-FB): A6 – *This Product/Service May Be Covered Under Medicare Part B*

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iii. 5H - Unknown Exposure/Risk
- Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights

4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
   i. P0 - Patient consulted
   Consultation with the patient to clarify or collect additional information
   ii. M0 - Prescriber consulted
   Communication with prescriber related to collection of information or clarification of a drug therapy concern.
   iii. R0 - Pharmacist consulted other source
   Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

MA Only - Medicare Advantage (Part B Benefit ONLY, No Part D) for Hepatitis B Vaccine

1. Hepatitis B vaccine claim submitted
2. If the Result of Service Code (441-E6) field does not contain one of the new risk values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – DUR Reject Error
   ii. Reason For Service Code (439-E4): UE - Hepatitis B Risk Determination Required
3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of XX – *Hepatitis B Risk Determination Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
   iii. 5D – *Low Risk of Hepatitis B*
      a. Payer Response: Claim rejects with Reject Code (511-FB): 620 – *This Product/Service May Be Covered Under Medicare Part D*
   iv. 5E – *Medium/High Risk of Hepatitis B*
      a. Claim continues to adjudicate under the MA Only benefit
   v. 5H - Unknown Exposure/Risk
      a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
   i. P0 - Patient consulted
   Consultation with the patient to clarify or collect additional information
   ii. M0 - Prescriber consulted
   Communication with prescriber related to collection of information or clarification of a drug therapy concern.
   iii. R0 - Pharmacist consulted other source
   Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

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MAPD – Medicare Advantage Prescription Drug (Part B+D BENEFITS) for Hepatitis B Vaccine

1. Hepatitis B vaccine claim submitted
2. If the Result of Service Code (441-E6) field does not contain one of the new risk values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – DUR Reject Error
   ii. Reason For Service Code (439-E4): UE - *Hepatitis B Risk Determination Required*
3. Pharmacy resubmits claim with one of the below Result of Service Code values:
   i. 5D – *Low Risk of Hepatitis B*
   Payer Response: Claim continues to adjudicate under the MAPD Part D benefit
   ii. 5E – *Medium/High Risk of Hepatitis B*
   Payer Response: Claim continues to adjudicate under the MAPD Part B benefit
   iii. 5H - Unknown Exposure/Risk
   Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
   i. P0 - Patient consulted
   Consultation with the patient to clarify or collect additional information
   ii. M0 - Prescriber consulted
   Communication with prescriber related to collection of information or clarification of a drug therapy concern.
   iii. R0 - Pharmacist consulted other source
   Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

Vaccine Billing DUR Code Set Sample Claim Request Matrices

Scenario	**Request: Reason for Service Code (439-E4)**	**Professional Service Code (440-E5)** ***Only submitted if specified in trading partner agreement***	**Result of Service Code (441-E6)**
Pharmacy Proactively Submits Hepatitis B Risk Determination	UE – Hepatitis B Risk Determination Required	P0 - Patient Consulted M0 – Prescriber Consulted R0 – Pharmacy Consulted Other Sources	5D- Low Risk of Hepatitis B, or 5E – Medium/High Risk of Hepatitis B 5H - Unknown Exposure/Risk
Plan Returns Reject 88 - DUR Error with Reason for Service Code EU – Hepatitis B Risk Determination Required	UE – Hepatitis B Risk Determination Required	P0 - Patient Consulted M0 – Prescriber Consulted R0 – Pharmacy Consulted Other Sources	5D- Low Risk of Hepatitis B, or 5E – Medium/High Risk of Hepatitis B 5H - Unknown Exposure/Risk

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Medicare Part B vs Medicare Part D Vaccine Billing

Question: For vaccines that can be covered under either Medicare Part B or Part D depending on the patient's circumstances, what information should the pharmacy submit on the claim to allow the payer to make the payment determination?

Answer: The new External Code List (ECL) values below have been created for use with existing ECL values to support a standardized point of service process to communicate information about Part B vs Part D vaccines. For selected vaccines, such as tetanus and rabies, the pharmacy will indicate whether the patient is getting the vaccine due to possible exposure due to illness or injury (i.e., post-exposure, such as a puncture wound or animal bite) or whether it's needed for general prevention or upcoming travel (i.e., pre-exposure).

Reason for Service Code (439-E4):
One new Reason for Service Code (439-E4) value has been created for the payer to return on a rejected response, indicating more information is needed to complete vaccine billing.

- UF – Pre- vs Post-Exposure Vaccine Information Required
  Code indicating the reason for the vaccine administration is needed to determine coverage.

Result of Service Code (441-E6):
Three new Result of Service Code (441-E6) values have been created for the pharmacy to communicate whether the vaccine is being administered pre- or post-exposure.

- 5F – Maintenance/Travel Vaccine
  Vaccine is administered as part of maintenance/routine vaccine schedule or in preparation for travel.
- 5G – Post-Exposure Vaccine
  Vaccine is administered in response to an injury or direct exposure to a disease or condition.
- 5H - Unknown Exposure/Risk
  Exposure or risk to determine vaccine coverage is unknown to pharmacy.

Pharmacies could proactively submit an applicable Result of Service Code (441-E6) value to identify the reason for vaccine.

If the information is not on the submitted claim and is necessary for the payer to complete the claim adjudication process, payers can initiate the point of service communication process using the specified ECL values as outlined below.

Refer to the Vaccine Billing DUR Code Set Sample Matrices at the end of this FAQ for a combination of Reason for Service (439-E4) and Result of Service Code (441-E6) code values that could be submitted on the request.

POINT OF SERVICE CLAIMS PROCESSING GUIDANCE BASED ON MEDICARE PLAN TYPE
PDP - Prescription Drug Plan (Part D Benefit ONLY, No Part B) for Pre- vs Post-Exposure Vaccine

1. Claim submitted for a vaccine covered by Part D for general prevention/ travel.
2. If the Result of Service Code (441-E6) field does not contain one of the new reason for vaccine values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*
   ii. Reason For Service Code (439-E4): UF – *Pre- or Post-Exposure Vaccine Information Required*

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3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of UF – *Pre- or Post-Exposure Vaccine Information Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
    i. 5F – *Maintenance/Travel Vaccine*
        a. Payer Response: Claim continues to adjudicate under the PDP benefit
    ii. 5G – *Post-Exposure Vaccine*
        a. Payer Response: Claim rejects with Reject Code (511-FB): A6 – *This Product/Service May Be Covered Under Medicare Part B*
    iii. 5H - Unknown Exposure/Risk
        a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    Consultation with the patient to clarify or collect additional information
    ii. M0 - Prescriber consulted
    Communication with prescriber related to collection of information or clarification of a drug therapy concern.
    iii. R0 - Pharmacist consulted other source
    Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

MA Only - Medicare Advantage (Part B Benefit ONLY, No Part D) for Pre- vs Post-Exposure Vaccine

1. Claim submitted under Part B for post-exposure prevention (ex: tetanus, rabies, hepatitis A)
2. If the Result of Service Code (441-E6) field does not contain one of the new reason for vaccine values, the claim may reject as follows:
    i. Reject Code (511-FB): 88 – *DUR Reject Error*
    ii. Reason For Service Code (439-E4): UF - *Pre- or Post-Exposure Vaccine Information Required*
3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of UF – *Pre- or Post-Exposure Vaccine Information Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
    i. 5F – *Maintenance/Travel Vaccine*
        a. Payer Response: Claim rejects with Reject Code (511-FB): 620 – *This Product/Service May Be Covered Under Medicare Part D*
    ii. 5G – *Post-Exposure Vaccine*
        a. Claim continues to adjudicate under the MA Only benefit
    iii. 5H - *Unknown Exposure/Risk*
        a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights

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4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    Consultation with the patient to clarify or collect additional information
    ii. M0 - Prescriber consulted
    Communication with prescriber related to collection of information or clarification of a drug therapy concern.
    iii. R0 - Pharmacist consulted other source
    Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

MAPD – Medicare Advantage Prescription Drug (Part B+D BENEFITS) for Pre- vs Post-Exposure Vaccine

1. Claim submitted for a vaccine covered by Part D for general prevention/travel and under Part B for post-exposure prevention (ex: tetanus, rabies, hepatitis A)
2. If the Result of Service Code (441-E6) field does not contain one of the new reason for vaccine values, the claim may reject as follows:
    i. Reject Code (511-FB): 88 – *DUR Reject Error*
    ii. Reason For Service Code (439-E4): UF - *Pre- or Post-Exposure Vaccine Information Required*
3. Pharmacy resubmits claim with one of the below Result of Service Code values:
    i. 5F – *Maintenance/Travel Vaccine*
        a. Payer Response: Claim continues to adjudicate under the MAPD Part D benefit
    ii. 5G – *Post-Exposure Vaccine*
        a. Payer Response: Claim continues to adjudicate under the MAPD Part B benefit
    iii. 5H - *Unknown Exposure/Risk*
        a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    Consultation with the patient to clarify or collect additional information
    ii. M0 - Prescriber consulted
    Communication with prescriber related to collection of information or clarification of a drug therapy concern.
    iii. R0 - Pharmacist consulted other source
    Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

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Vaccine Billing DUR Code Set Sample Claim Request Matrices

Scenario	Request: Reason for Service Code (439-E4)	Professional Service Code (440-E5) *Only submitted if specified in trading partner agreement*	Result of Service Code (441-E6)
Pharmacy Proactively Submits Vaccine Purpose	UF – Pre- or Post-Exposure Vaccine Information Required	P0 - Patient Consulted M0 – Prescriber Consulted R0 – Pharmacy Consulted Other Sources	5F- Maintenance/Travel Vaccine, or 5G – Post-Exposure Vaccine 5H - Unknown Exposure/Risk
Plan Returns Reject 88 - DUR Error with Reason for Service Code UF – Pre- or Post-Exposure Vaccine	UF – Pre- or Post-Exposure Vaccine Information Required	P0 - Patient Consulted M0 – Prescriber Consulted R0 – Pharmacy Consulted Other Sources	5F- Maintenance/Travel Vaccine, or 5G – Post-Exposure Vaccine 5H - Unknown Exposure/Risk

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