Express Scripts, Inc.
NCPDP Version D.0 Payer Sheet
Medicare

IMPORTANT NOTE: ***Express Scripts is currently accepting NCPDP Version D.0 electronic transactions. This documentation is to be used for programming the fields and values Express Scripts will accept when processing these claims.***

Claim transaction segments not depicted within this document may be accepted during the transmission of a claim. However, Express Scripts may not use the information submitted to adjudicate claims.

General Information:

Payer Name: Express Scripts, Inc.	Date: **March 1, 2013**
Plan Name/Group Name: Express Scripts, Inc. - Standard Plan - Exceptions Noted	
Processor: Express Scripts, Inc.	Switch:
Effective as of: March 1, 2013	Version/Release Number: D.0
NCPDP Data Dictionary Version Date: October 2011	NCPDP External Code List Version Date: October 2011
	NCPDP Emergency External Code List Version Date: July 2012
Contact/Information Source: Network Contracting & Management Account Manager, or (800) 824-0898, or Express-Scripts.com	
Testing Window: As determined by testing coordinator	
Pharmacy Help Desk Info: (800) 824-0898	
Other versions supported: N/A	

Section I: Claim Billing (In Bound)

Transaction Header Segment - Mandatory in all cases

Field #	NCPDP Field Name	Value	Payer Usage
1Ø1-A1	BIN Number	**ØØ3858** (or as assigned by ESI)	M
1Ø2-A2	Version Release Number	DØ=Version D.0	M
1Ø3-A3	Transaction Code	B1=Billing	M
1Ø4-A4	Processor Control Number	PCN= MD (or as assigned by ESI)	M
1Ø9-A9	Transaction Count	1=One Occurrence	M
2Ø2-B2	Service Provider ID Qualifier	Ø1=NPI	M
2Ø1-B1	Service Provider ID	Pharmacy or Dispensing Physician NPI	M
4Ø1-D1	Date of Service		M
11Ø-AK	Software Vendor/Certification ID		M

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if "x", not required if "y"

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Insurance Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	Ø4=Insurance	M
3Ø2-C2	Cardholder ID	ID assigned to the cardholder	M
312-CC	Cardholder First Name		R
313-CD	Cardholder Last Name		R
524-FO	Plan ID		R
3Ø9-C9	Eligibility Clarification Code	Ø=Not Specified 1=No Override 2=Override 3=Full Time Student 4=Disabled Dependent 5=Dependent Parent 6=Significant Other	R
3Ø1-C1	Group ID	As appears on card	R
3Ø3-C3	Person Code		R
3Ø6-C6	Patient Relationship Code	Ø=Not Specified 1=Cardholder – Individual who is enrolled in and receives benefits from a health plan 2=Spouse – Patient is the husband/wife/partner of the cardholder 3=Child – Patient is a child of the cardholder 4=Other – Relationship to cardholder is not precise	R
359-2A	Medigap ID		O

Patient Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	Ø1=Patient	M
331-CX	Patient ID Qualifier		O
332-CY	Patient ID	As indicated on member ID card	O
3Ø4-C4	Date of Birth		R
3Ø5-C5	Patient Gender Code	1=Male 2=Female	R
31Ø-CA	Patient First Name	Example: John	R
311-CB	Patient Last Name	Example: Smith	R
322-CM	Patient Street Address		O
323-CN	Patient City		O
324-CO	Patient State or Province		O
325-CP	Patient Zip/Postal Code		RW Emergency/Disaster Situations; include current ZIP code of displaced patient
3Ø7-C7	Place of Service	Ø1 = Pharmacy	R
384-4X	Patient Residence		R

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if “x”, not required if “y”

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Claim Segment – Mandatory (Payer does not support partial fills)

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	Ø7=Claim	M
455-EM	Prescription/Service Reference Number Qualifier	1=Rx Billing *Pharmacist should enter a "1" when processing claim for a Medicare Part D vaccine drug and vaccine administration	M
4Ø2-D2	Prescription/Service Reference Number		M
436-E1	Product/Service ID Qualifier	ØØ=Not Specified* Ø3=National Drug Code	M
4Ø7-D7	Product/Service ID*		M
442-E7	Quantity Dispensed		R
4Ø3-D3	Fill Number	Ø=Original Dispensing 1 to 99 = Refill number	R
4Ø5-D5	Days Supply		R
4Ø6-D6	Compound Code	1=Not a Compound 2=Compound*	R *Requires the compound segment be sent
4Ø8-D8	Dispense as Written (DAW)/Product Selection Code	Ø=No Product Selection Indicated -This is the field default value appropriately used for prescriptions for single source brand, co-branded/co-licensed, or generic products. For a multi-source branded product with available generic(s), DAW Ø is not appropriate and may result in a reject. 1=Substitution Not Allowed by Prescriber -This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is Medically Necessary to be Dispensed As Written. DAW1 is based on prescriber instruction and not product classification. 2=Substitution Allowed-Patient Requested Product Dispensed -This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. 3=Substitution Allowed-Pharmacist Selected Product Dispensed-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when	R

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if "x", not required if "y"

		the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. 5=Substitution Allowed-Brand Drug Dispensed as a Generic-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity. 7=Substitution Not Allowed-Brand Drug Mandated by Law-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product, even though generic versions of the product may be available in the marketplace.	
414-DE	Date Prescription Written		R
415-DF	Number of Refills Authorized	Ø=No refills authorized 1 through 99, with 99 being as needed, refills unlimited	R
419-DJ	Prescription Origin Code	Ø=Not known 1=Written 2=Telephone 3=Electronic 4=Facsimile 5=Pharmacy	R
354-NX	Submission Clarification Code Count	Maximum count of 3	RW (Submission Clarification Code (42Ø – DK) is used)
42Ø-DK	Submission Clarification Code		RW (Clarification is needed and value submitted is greater than zero Ø). The value of 2 is used to respond to a Max Daily Dose/High Dose Reject.)
3Ø8-C8	Other Coverage Code	Ø=Not specified by patient 1=No other coverage 2=Other coverage exists - payment collected** 3=Other coverage billed - claim not covered** 4=Other coverage exists - payment not collected**	R

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429-DT	Special Packaging Indicator		RW (Claim is short-cycle filled for LTC)
6ØØ-28	Unit of Measure	EA=Each GM=Grams ML=Milliliters	O
418-DI	Level of Service	Ø=Not specified 1=Patient consultation (professional service involving provider/patient discussion of disease, therapy or medication regimen or other health issues) 2=Home delivery—provision of medications from pharmacy to patient's place of residence 3=Emergency—urgent provision of care 4=24 hour service—provision of care throughout the day and night 5=Patient consultation regarding generic product selection—professional service involving discussion of alternatives to brand-name medications 6=In-Home Service—provision of care in patient's place of residence	O
461-EU	Prior Authorization Type Code	Ø=Not specified 1=Prior Authorization 9=Emergency Preparedness***	RW (462-EV is used)
462-EV	Prior Auth Number Submitted	Submitted when requested by processor. Examples: Prior authorization procedures for physician-authorized dosage or days supply increases for reject 79 'Refill Too Soon'.	RW (461-EU is equal to 1 or 9)
357-NV	Delay Reason Code		RW (Needed to specify the reason that submission of the transaction has been delayed)†
995-E2	Route of Administration		RW (Required for Compounds)
147-U7	Pharmacy Service Type	1=Community/Retail 3=Home Infusion Therapy 5=Long Term Care Pharmacy	R

*The Product/Service ID (4Ø7-D7) must contain a value of "Ø" and Product/Service ID Qualifier (436-E1) must contain a value of "ØØ" when used for multi-ingredient compounds.
**Requires the COB segment be sent.
***For value "9=Emergency Preparedness" Field *462-EV Prior Authorization Number Submitted* supports the following values when an emergency healthcare disaster has been officially declared by the appropriate U.S. government agency.
911ØØØØØØØ1 Emergency Preparedness (EP) Refill Too Soon Edit Override

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†All values are accepted. Values of 1, 2, 7, 8, 9, 10 may be allowed to override Reject 81 (Claim Too Old) for member claims UPGRADED to the new adjudication system. .

LTC Only Overrides Allowed For:
Refill too soon: 15 = LTC Replacement Medication
16 = LTC Emergency box (kit) or automated dispensing machine
17 = LTC Emergency Supply Remainder
18 = LTC Patient Admit/Readmit Indicator
Duplicate claims:
15 = LTC Replacement Medication
16 = LTC Emergency box (kit) or automated dispensing machine
17 = LTC Emergency Supply Remainder
No Quantity Level Limits (QLL) overrides are allowed in these situations.

Pricing Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	11=Pricing	M
4Ø9-D9	Ingredient Cost Submitted		R
412-DC	Dispensing Fee Submitted		R
433-DX	Patient Paid Amount Submitted		O
438-E3	Incentive Amount Submitted	Vaccine Administration Fee	RW – Vaccines
481-HA	Flat Sales Tax Amount Submitted		RW (Value has an effect on Gross Amount (43Ø-DU) calculation)
482-GE	Percentage Sales Tax Amount Submitted		RW (Value has an effect on Gross Amount (43Ø-DU) calculation)
483-HE	Percentage Sales Tax Rate Submitted		RW (Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used)
484-JE	Percentage Sales Tax Basis Submitted		RW (Percentage Sales Tax Amount Submitted

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if “x”, not required if “y”

			(482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used)
426-DQ	Usual and Customary Charge		R
43Ø-DU	Gross Amount Due		R
423-DN	Basis of Cost Determination		R

Prescriber Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	Ø3=Prescriber	M
466-EZ	Prescriber ID Qualifier	Ø1=NPI Ø8=State License 12=DEA (Drug Enforcement Administration)	R
411-DB	Prescriber ID	NPI	R
427-DR	Prescriber Last Name		RW (Prescriber ID Qualifier (466-EZ) = Ø8)
367-2N	Prescriber State/Province Address		RW (Prescriber ID Qualifier (466-EZ) = Ø8, 12)

Express Scripts edits the qualifiers in field 466-EZ. A valid Prescriber ID is required for all claims. Claims unable to be validated may be subject to post-adjudication review.

* For vaccines, an individual NPI is required. It may be the prescriber who wrote the prescription or alternate care provider (pharmacist, nurse practitioner, etc.) who administered the vaccine.

Coordination of Benefits/Other Payments Segment – Situational
(Will support only one transaction per transmission)

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	Ø5=COB/Other Payments	M
337-4C	Coordination of Benefits/Other Payments Count	Maximum count of 3	M
338-5C	Other Payer Coverage Type		M
339-6C	Other Payer ID Qualifier		R
34Ø-7C	Other Payer ID		R
443-E8	Other Payer Date		R
341-HB	Other Payer Amount Paid Count		R
342-HC	Other Payer Amount Paid Qualifier	Ø7=Drug Benefit 1Ø=Sales Tax	R

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if “x”, not required if “y”

431-DV	Other Payer Amount Paid	Valid value of greater than $0 to reflect sum of Other Payer Amount Paid Qualifier	R
471-5E	Other Payer Reject Count	Maximum count of 5	RW (Other Payer Reject Code (472-6E) is used)
472-6E	Other Payer Reject Code		RW (Other Payer Reject Count (471-5E) is used)

The COB segment and all required fields must be sent if the Other Coverage Code (3Ø8-C8) field with values = 2 through 4 are submitted in the claim segment.

Note: If field 3Ø8-C8 (Other Coverage Code) is populated with:

- Value of 2 = Other coverage exists – payment collected; fields 341-HB, 342-HC and 431-DV are required and must have values entered. Field 431-DV must **not** be zero ($0.00). The sum of all occurrences must not be zero.
- Value of 3 = Other coverage billed – claim not covered; fields 471-5E and 472-6E are required and must have values entered.
- Value of 4 = Other coverage exists – payment not collected; fields 341-HB, 342-HC and 431-DV are required and must have values entered. Field 431-DV must be zero ($0.00). The sum of all occurrences must be zero.

DUR/PPS Segment – Situational

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	Ø8=DUR/PPS	M
473-7E	DUR/PPS Code Counter	1=Rx Billing (maximum of 9 occurrences)	R
439-E4	Reason for Service Code	DA=Drug-Allergy DC=Drug-Disease (Inferred) DD=Drug-Drug Interaction** HD=High Dose (Maximum Daily Dose) ID=Ingredient Duplication LD=Low Dose (Minimum Daily Dose) NP=New Patient Processing PG=Drug-Pregnancy SX=Drug-Gender TD=Therapeutic Duplication SD=Suboptimal Drug/Indication	R
44Ø-E5	Professional Service Code	ØØ=No intervention MØ=Prescriber consulted** PE=Patient education/instruction PØ=Patient consulted RØ=Pharmacist consulted other source MA=Medication Administered – indicates the administration of a covered vaccine* **	R

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if “x”, not required if “y”

441-E6	Result of Service Code	1A=Filled As Is, False Positive 1B=Filled As Is 1C=Filled, With Different Dose 1D=Filled, With Different Directions 1E=Filled, With Different Drug 1F=Filled, With Different Quantity 1G=Filled, With Prescriber Approval** 2A=Prescription Not Filled 2B=Not Filled, Directions Clarified 3C=Discontinued Drug 3E=Therapy Changed 3H=Follow-Up/Report	R
474-8E	DUR/PPS Level of Effort	11=Level 1 (Lowest) 12=Level 2 13=Level 3 14=Level 4 (Highest)	R

*Indicates the claim billing includes a charge for the administration of the vaccine; leave blank if dispensing vaccine without administration.
**Indicates the code value accepted for member claims UPGRADED to the new adjudication system. All other codes are still accepted for legacy Express Scripts plan sponsors that have not been upgraded to the new system.

Compound Segment – Situational (Must be present on a compound claim)
(Will support only transaction per transmission)

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	1Ø=Compound	M
45Ø-EF	Compound Dosage Form Description Code		M
451-EG	Compound Dispensing Unit Form Indicator	1=Each 2=Grams 3=Milliliters	M
447-EC	Compound Ingredient Component Count	Maximum 25 ingredients	M
488-RE	Compound Product ID Qualifier	Ø3=NDC	M
489-TE	Compound Product ID	At least 2 ingredients and 2 NDC #s. Number should equal field 447-EC.	M “R”
448-ED	Compound Ingredient Quantity		M “R”
449-EE	Compound Ingredient Drug Cost		M “R”
49Ø-UE	Compound Ingredient Basis of Cost Determination		R “R”

Clinical Segment – Situational

This segment may be required as determined by benefit design. When the segment is submitted, the fields defined below are required.

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	13=Clinical	M

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if “x”, not required if “y”

491-VE	Diagnosis Code Count	Maximum count of 5	R
492-WE	Diagnosis Code Qualifier		R
424-DO	Diagnosis Code		R

Section II: Response Claim Billing (Out Bound)

Response Header Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
1Ø2-A2	Version Release Number	DØ =Version D.Ø	M
1Ø3-A3	Transaction Code	B1=Billing	M
1Ø9-A9	Transaction Count	1=One Occurrence	M
5Ø1-FI	Header Response Status	A=Accepted R=Rejected	M
2Ø2-B2	Service Provider ID Qualifier	Ø1=NPI	M
2Ø1-B1	Service Provider ID	NPI	M
4Ø1-D1	Date of Service		M

Response Message Segment - Optional

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	2Ø=Response Message	M
5Ø4-F4	Message		O

Response Insurance Segment – Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	25=Response Insurance	M
3Ø1-C1	Group ID		O*
524-FO	Plan ID		RW* (Needed to identify the actual plan ID used when multiple group coverage exists)
545-2F	Network Reimbursement ID	Network ID	R
568-J7	Payer ID Qualifier		O
569-J8	Payer ID		O
3Ø2-C2	Cardholder ID		R

*The Group ID (3Ø1-C1) or Plan ID (524-FO) field may be returned on paid claim responses until January 1, 2014.

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Response Status Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	21=Response Status	M
112-AN	Transaction Response Status	P=Paid D=Duplicate of Paid R=Reject	M
5Ø3-F3	Authorization Number		RW (Transaction Response Status=P)
547-5F	Approved Message Code Count	Maximum count of 5	O
548-6F	Approved Message Code	ØØ5 = Filled During Transition Benefit/Prior Authorization Required ØØ6 = Filled During Transition Benefit/Non-Formulary ØØ7 = Filled During Transition Benefit/Other Rejection Ø18 = Provide Beneficiary with CMS Notice of Appeal Rights Ø19 = Prescriber ID Submitted is Not Found or is Inactive	O
51Ø-FA	Reject Count	Maximum count of 5	RW (Transaction Response Status = R)
511-FB	Reject Code		RW (Transaction Response Status = R)
546-4F	Reject Field Occurrence Indicator		RW (If repeating field is in error to identify repeating field occurrence)
13Ø-UF	Additional Message Information Count		RW (Additional Message (526-FQ) is used)
132-UH	Additional Message Information Qualifier	Ø1- Ø9 = Free-Form Text 1Ø = Next Available Fill Date (CCYYMMDD)	RW (Additional Message (526-FQ) is used)
526-FQ	Additional Message Information		RW (Additional text is needed for clarification or detail)

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if “x”, not required if “y”

131-UG	Additional Message Information Continuity		RW (Current repetition of Additional Message Information (526-FQ) is used and another repetition (526-FQ) follows, and text is continuation of the current)
549-7F	Help Desk Phone Number Qualifier		O
55Ø-8F	Help Desk Phone Number		O
987-MA	URL		R

Response Claim Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	22=Response Claim	M
455-EM	Prescription/Service Reference Number Qualifier	1=Rx Billing	M
4Ø2-D2	Prescription/Service Reference Number		M

Response Pricing Segment – Mandatory
(This segment will not be included with a rejected response)

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	23=Response Pricing	M
5Ø5-F5	Patient Pay Amount		R
5Ø6-F6	Ingredient Cost Paid		R
5Ø7-F7	Dispensing Fee Paid		R
557-AV	Tax Exempt Indicator		RW (If sender and/or patient is tax exempt and exemption applies to this billing)

558-AW	Flat Sales Tax Amount Paid		RW (Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (Ø) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement)
559-AX	Percentage Sales Tax Amount Paid		RW (Required if Percentage Tax Amount Submitted (482-GE) is greater than zero (Ø) or Percentage Sales Tax Rate Paid (56Ø-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used)
56Ø-AY	Percentage Sales Tax Rate Paid		RW (Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø))
561-AZ	Percentage Sales Tax Basis Paid	ØØ=Not specified Ø2=Ingredient Cost Ø3=Ingredient Cost + Dispensing Fee	O
521-FL	Incentive Amount Paid		O
566-J5	Other Payer Amount Recognized		O
5Ø9-F9	Total Amount Paid		R
522-FM	Basis of Reimbursement Determination		R
523-FN	Amount Attributed to Sales Tax		O
512-FC	Accumulated Deductible Amount		O
513-FD	Remaining Deductible Amount		O
514-FE	Remaining Benefit Amount		O

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if “x”, not required if “y”

517-FH	Amount Applied to Periodic Deductible		RW (Patient Pay Amount (5Ø5-F5) includes deductible)
518-FI	Amount of Copay		RW (Patient Pay Amount (5Ø5-F5) includes copay as patient financial responsibility)
52Ø-FK	Amount Exceeding Periodic Benefit Maximum		RW (Patient Pay Amount (5Ø5-F5) includes amount exceeding periodic benefit maximum)
571-NZ	Amount Attributed to Processor Fee		RW (Customer is responsible for 100% of prescription payment and when the provider net sale is less than the amount the customer is expected to pay)
575-EQ	Patient Sales Tax Amount		RW (Used when necessary to identify Patient's portion of the Sales Tax)
574-2Y	Plan Sales Tax Amount		RW (Used when necessary to identify Plan's portion of the Sales Tax)
572-4U	Amount of Coinsurance		RW (Patient Pay Amount (5Ø5-F5) includes coinsurance as patient financial responsibility)

392-MU	Benefit Stage Count		RW (Required if Benefit Stage Amount (394-MW) is used)
393-MV	Benefit Stage Qualifier	Blank = Not specified Ø1 = Deductible Ø2 = Initial Benefit Ø3 = Coverage Gap (donut hole) Ø4 = Catastrophic Coverage 5Ø = Not paid under Part D, Paid Under Part C benefit (for MA-PD plan) 6Ø = Not paid under Part D, paid as or under a supplemental benefit only.* 61 = Part D drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only.** 62 = Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only.** 7Ø = Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing 8Ø = Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing 9Ø = Enhanced or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan*** (Occurs up to 4 times)	RW (Required if Benefit Stage Amount (394-MW) is used)
394-MW	Benefit Stage Amount		RW (Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. When the plan is a participant in a Medicare Part D program that requires reporting of benefit stage-specific financial amounts)

577-G3	Estimated Generic Savings		RW (Patient selects brand drug when generic was available)
128-UC	Spending Account Amount Remaining		RW (If known when transaction had spending account dollars reported as part of the patient pay amount)
129-UD	Health Plan-Funded Assistance Amount		RW (Patient meets the plan-funded assistance criteria to reduce Patient Pay Amount (5Ø5-F5)
134-UK	Amount Attributed to Product Selection/Brand Drug		RW (Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand drug)
137-UP	Amount Attributed to Coverage Gap		RW (Required when the patient's financial responsibility is due to the coverage gap)

*Only available for use on claims with fill dates of 12/31/2012 and prior.
**Benefit Stage Qualifier (393-MV) values 61 or 62 replace value of 6Ø. Available for use as of 1/1/13.
*** Available for use as of 1/1/13.

Response DUR/PPS Segment - Situational

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	24=Response DUR/PPS	M
567-J6	DUR/PPS Response Code Counter	Maximum 3 occurrences supported	RW (Reason for Service Code (439-E4) is used)

439-E4	Reason for Service Code	AT=Additive Toxicity* DA=Drug-Allergy DC=Drug-Disease (Inferred) DD=Drug-Drug Interaction* ER=Overuse HD=High Dose (Maximum Daily Dose) ID=Ingredient Duplication LD=Low Dose (Minimum Daily Dose) NP=New Patient Processing PG=Drug-Pregnancy SX=Drug-Gender TD=Therapeutic Duplication SD=Suboptimal Drug/Indication	O
528-FS	Clinical Significance Code		O
529-FT	Other Pharmacy Indicator		O
53Ø-FU	Previous Date of Fill		O
531-FV	Quantity of Previous Fill		O
532-FW	Database Indicator		O
533-FX	Other Prescriber Indicator		O
544-FY	DUR Free Text Message		O

*Indicates the code value returned in response for member claims UPGRADED to the new adjudication system.

Response Coordination of Benefits/Other Payers – Situational
(This segment will not be included with a rejected response)

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	28=Response Coordination of Benefits/Other Payers	M
355-NT	Other Payer ID Count	Maximum count of 3	M
338-5C	Other Payer Coverage Type		M
339-6C	Other Payer ID Qualifier		RW (Other Payer ID (34Ø-7C) is used)
34Ø-7C	Other Payer ID		RW (Other insurance information is available for COB)
991-MH	Other Payer Processor Control Number		RW (Other insurance information is available for COB)
356-NU	Other Payer Cardholder ID		RW (Other insurance information is available for COB)
992-MJ	Other Payer Group ID		RW (Other insurance

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if “x”, not required if “y”

			information is available for COB)
142-UV	Other Payer Person Code		RW (Needed to uniquely identify family members within the Cardholder ID, as assigned by the other payer)
127-UB	Other Payer Help Desk Phone Number		RW (Needed to provide support telephone number of the other payer to the receiver)

Section III: Reversal Transaction (In Bound)

Transaction Header Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
1Ø1-A1	BIN Number	**ØØ3858** (or as used on original claim submission)	M
1Ø2-A2	Version Release Number	DØ=Version D.Ø	M
1Ø3-A3	Transaction Code	B2=Reversal	M
1Ø4-A4	Processor Control Number	MD (or as used on original claim submission)	M
1Ø9-A9	Transaction Count	1=One Occurrence, one reversal per B2 transmission	M
2Ø2-B2	Service Provider ID Qualifier	Ø1=NPI	M
2Ø1-B1	Service Provider ID	NPI	M
4Ø1-D1	Date of Service		M
11Ø-AK	Software Vendor/Certification ID		M

Note: Reversal window is 9Ø days.

Insurance Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	Ø4=Insurance	M
3Ø2-C2	Cardholder ID	ID assigned to the cardholder	M

Claim Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	Ø7=Claim	M
445-EM	Prescription /Service Reference Number Qualifier	1=Rx Billing	M

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if “x”, not required if “y”

4Ø2-D2	Prescription/Service Reference Number		M
436-E1	Product/Service ID Qualifier	Ø3=National Drug Code	R
4Ø7-D7	Product/Service ID		R
4Ø3-D3	Fill Number		R
3Ø8-C8	Other Coverage Code	2=Other coverage exists-payment collected* 3=Other coverage exists-this claim not covered* 4=Other coverage exists-payment not collected*	R

*Please use ther Coverage Code submitted on the original COB transaction.

Coordination of Benefits/Other Payments Segment – Situational
(Will support only one transaction per transmission)

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	Ø5=COB/Other Payments	M
337-4C	Coordination of Benefits/Other Payments Count	Maximum count of 3	M
338-5C	Other Payer Coverage Type		M

Section IV: Reversal Response Transaction (Out Bound)

Response Header Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
1Ø2-A2	Version Release Number	DØ=Version D.Ø	M
1Ø3-A3	Transaction Code	B2=Reversal	M
1Ø9-A9	Transaction Count	1=One Occurrence, per B2 transmission	M
5Ø1-FI	Header Response Status	A=Accepted R=Rejected	M
2Ø2-B2	Service Provider ID Qualifier	Ø1=NPI	M
2Ø1-B1	Service Provider ID	NPI	M
4Ø1-D1	Date of Service		M

Response Message Segment - Situational

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	2Ø=Response Message	M
5Ø4-F4	Message		O

Response Status Segment - Situational

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	21=Response Status	M
112-AN	Transaction Response Status	A=Approved R=Rejected	M

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if “x”, not required if “y”

51Ø-FA	Reject Count	Maximum count of 5	RW (Transaction Response Status=R)
511-FB	Reject Code		RW"R" (Transaction Response Status=R)
549-7F	Help Desk Phone Number Qualifier		O
55Ø-8F	Help Desk Phone Number		O

Response Claim Segment - Mandatory

Field #	NCPDP Field Name	Value	Payer Usage
111-AM	Segment Identification	22=Response Claim	M
455-EM	Prescription/Service Reference Number Qualifier	1=Rx Billing	M
4Ø2-D2	Prescription/Service Reference Number		M

Payer Usage: M=Mandatory, O=Optional, R=Required by ESI to expedite claim processing, "R"=Repeating Field, RW=Required when; required if “x”, not required if “y”