

Florida Healthcare Plan – Medicare Part D

Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet

GENERAL INFORMATION

Payer Name: Florida Healthcare Plan		Date: Date of Publication of this Template	
Plan Name/Group Name: Florida Healthcare Plan (FHCP) – Medicare Part D Plans		BIN: 610084	PCN: DRCPROD01 = Production
Plan Name/Group Name: Florida Healthcare Plan – Medicare Part D (Test)		BIN: 610084	PCN: DRCPACCP01 = Test
Processor: ACS, A Xerox Company			
Effective as of: ???/2011		NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: July, 2007		NCPDP External Code List Version Date: March, 2010	
Contact/Information Source: Other references such as Provider Manuals, Payer phone number, web site, etc.			
Certification Testing Window: Certification Testing Dates			
Certification Contact Information: Certification phone number and information			
Provider Relations Help Desk Info: 800-365-4944			
Other versions supported: 5.1 supported through 12/31/2011			

OTHER TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name
B1	Billing
B3	Rebilling

FIELD LEGEND FOR COLUMNS

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

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

CLAIM BILLING/CLAIM REBILL TRANSACTION

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

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used	X	

Field #	Transaction Header Segment <i>NCPDP Field Name</i>	Value	<i>Payer Usage</i>	<i>Payer Situation</i>
101-A1	BIN NUMBER	610084	M	
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1 = Billing B3 = Rebill	M	Claim Billing, Claim Rebill
104-A4	PROCESSOR CONTROL NUMBER	DRCPROD01 = Production DRCPACCP = Test	M	
109-A9	TRANSACTION COUNT	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider Identifier (NPI) 07 = NCPDP Provider Number	M	
201-B1	SERVICE PROVIDER ID	NPI Number NCPDP Provider Number	M	

Transaction Header Segment			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
401-D1	DATE OF SERVICE	CCYYMMDD	M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	This will be provided by the provider's software vender	M	If no number is supplied, populate with zeros

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

Insurance Segment Segment Identification (111-AM) = "04"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID	As indicated on member's card	M	
301-C1	GROUP ID	000833833 or 0008340001	R	
303-C3	PERSON CODE	001 = Cardholder	R	Required to uniquely identify the family members within the Cardholder ID.

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

Patient Segment Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill	
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
304-C4	DATE OF BIRTH	CCYYMMDD	R	
305-C5	PATIENT GENDER CODE	0 = Not Specified 1 = Male 2 = Female	R	Required field in D.0
311-CB	PATIENT LAST NAME		R	Required field in D.0
335-2C	PREGNANCY INDICATOR	Blank = Not Specified 1 = Not pregnant 2 = Pregnant	RW	Required when submitting a claim for a pregnant member

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

Claim Segment Segment Identification (111-AM) = "07"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Rx Number assigned by the pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	03 = National Drug Code	M	
407-D7	PRODUCT/SERVICE ID	National Drug Code (NDC)	M	
442-E7	QUANTITY DISPENSED	Metric Decimal Quantity	R	
403-D3	FILL NUMBER	0 = Original Dispensing 1-99 = Refill number	R	
405-D5	DAYS SUPPLY		R	
406-D6	COMPOUND CODE	1 = Not a compound 2 = Compound	R	
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	0 = No Product Selection Indicated	R	Required when a DAW code is necessary for the processing of the claim Required field in D.0 Only DAW 0 allowed, all others rejected

Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
414-DE	DATE PRESCRIPTION WRITTEN	CCYYMMDD	R	
415-DF	NUMBER OF REFILLS AUTHORIZED	Ø = No refills authorized 1-99 = Authorized Refill number - with 99 being as needed, refills unlimited	R	
3Ø8-C8	OTHER COVERAGE CODE	Ø = Not Specified 1 = No other Coverage Identified 2 = Other coverage exists-payment collected 3 = Other coverage exists-this claim not covered 4 = Other coverage exists-payment not collected	R	Required for Coordination of Benefits. (COB method: OPAP)
461-EU	PRIOR AUTHORIZATION TYPE CODE	2 = Medical Certification	RW	Use for early refill
995-E2	ROUTE OF ADMINISTRATION	SNOMED CT Value	RW	Required when the Rx is a compound New Field - replaces 452-EH in 5.1 Compound Segment SNOMED CT Values required for D.0

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

Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
4Ø9-D9	INGREDIENT COST SUBMITTED		R	Format=s\$\$\$\$\$cc Required field in D.Ø.
412-DC	DISPENSING FEE SUBMITTED		RW	Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
43Ø-DU	GROSS AMOUNT DUE		R	Format=s\$\$\$\$\$cc

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

Prescriber Segment Segment Identification (111-AM) = "Ø3"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	Ø1=National Provider Identifier (NPI) 12 = Drug Enforcement Administration (DEA)	R	
411-DB	PRESCRIBER ID	NPI Number	R	

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 1 - Other Payer Amount Paid Repetitions Only	X	This is the scenario shown below

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

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE	Blank=Not Specified Ø1=Primary Ø2=Secondary Ø3=Tertiary	M	
339-6C	OTHER PAYER ID QUALIFIER			<i>Imp Guide:</i> Required if Other Payer ID (34Ø-7C) is used.
34Ø-7C	OTHER PAYER ID			<i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication.
443-E8	OTHER PAYER DATE			<i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.		<i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER			<i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used.
431-DV	OTHER PAYER AMOUNT PAID			<i>Imp Guide:</i> Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.		<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used.
472-6E	OTHER PAYER REJECT CODE			<i>Imp Guide:</i> Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered).

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

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	Required if DUR/PPS Segment is used.
439-E4	REASON FOR SERVICE CODE	See Attached list of valid Values	RW	Required when there is a conflict to resolve or reason for service to be explained (Max 9) Code identifying the type of utilization conflict

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				detected or the reason for the pharmacist's professional service.
44Ø-E5	PROFESSIONAL SERVICE CODE	See Attached list of valid Values	RW	Required when there is a professional service to be identified (Max 9) Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.
441-E6	RESULT OF SERVICE CODE	See Attached list of valid Values	RW	Required when There is a result of service to be Submitted (Max = 9). Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.

Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is situational	X	Required when billing for a compound

	Compound Segment Segment Identification (111-AM) = "1Ø"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	Ø1=Capsule Ø2=Ointment Ø3=Cream Ø4=Suppository Ø5=Powder Ø6=Emulsion Ø7=Liquid 1Ø=Tablet 11=Solution 12=Suspension 13=Lotion 14=Shampoo 15=Elixir 16=Syrup 17=Lozenge 18=Enema	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= National Drug Code (NDC)	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	

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

RESPONSE CLAIM BILLING/CLAIM REBILL PAYER SHEET TEMPLATE

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

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

GENERAL INFORMATION

Payer Name: Florida Health Care Plan Medicare Part D	Date: January 1, 2012	
Plan Name/Group Name: Florida Health Care Plan Medicare Part D	BIN: 610084	PCN DRCPROD01
Plan Name/Group Name: Florida Health Care Plan Medicare Part D (test)	BIN: 610084	PCN: DRCPACCP01

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

The following lists the segments and fields in a Claim Billing or Claim Rebill response (Paid or Duplicate of Paid) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

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

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

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

Response Message Segment	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE	Text Message	RW	Required if text is needed for clarification or detail. Variable length is from 1-200 characters.

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

Response Insurance Segment	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
301-C1	GROUP ID		R	Used to identify the group number used in claim adjudication.
524-FO	PLAN ID		R	Used to identify the actual plan ID that was used in claim adjudication.

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

Response Status Segment	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
503-F3	AUTHORIZATION NUMBER	17-digit FHCP TCN	R	
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
Response Claim Segment Segment Identification (111-AM) = "22"				
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
Response Pricing Segment Segment Identification (111-AM) = "23"				
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID		R	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		R	Required when sales tax applies
560-AY	PERCENTAGE SALES TAX RATE PAID		R	Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).
561-AZ	PERCENTAGE SALES TAX BASIS PAID		R	Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.
509-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		RW	<i>Imp Guide:</i> Required if Ingredient Cost Paid (506-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing.

	Response Pricing Segment Segment Identification (111-AM) = "23"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
523-FN	AMOUNT ATTRIBUTED TO SALES TAX		R	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes sales tax that is the financial responsibility of the member but is not also included in any of the other fields that add up to Patient Pay Amount.
514-FE	REMAINING BENEFIT AMOUNT		RW	<i>Imp Guide:</i> Provided for informational purposes only.
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes deductible
518-FI	AMOUNT OF COPAY		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes copay as patient financial responsibility.
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes amount exceeding periodic benefit maximum.
575-EQ	PATIENT SALES TAX AMOUNT		R	<i>Imp Guide:</i> Used when necessary to identify the Patient's portion of the Sales Tax.
574-2Y	PLAN SALES TAX AMOUNT		R	<i>Imp Guide:</i> Used when necessary to identify the Plan's portion of the Sales Tax.
572-4U	AMOUNT OF COINSURANCE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes coinsurance as patient financial responsibility.
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	R	Required if Benefit Stage Amount (394-MW) is used.
393-MV	BENEFIT STAGE QUALIFIER		R	Required if Benefit Stage Amount (394-MW) is used.
394-MW	BENEFIT STAGE AMOUNT		R	<i>Imp Guide:</i> Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts.

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is situational	X	

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE		RW	<i>Imp Guide:</i> Required if utilization conflict is detected.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
528-FS	CLINICAL SIGNIFICANCE CODE	Blank = Not Specified 1 = Major - Code indicating that an event, transaction, etc. is of the highest importance; action required to prevent adverse drug event. 2 = Moderate – Code indicating that an event, transaction, etc. is of mid-level significance; requires thoughtful review before prescribing/dispensing the medication. Risk vs. benefit should be evaluated. 3 = Minor – Code indicating a non-life threatening, annoying, or now-well-documented effect which may or may not require a change in drug therapy. 9 = Undetermined - value to describe a professional service with variable or unknown severity.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR	Ø = Not Specified 1 = Your Pharmacy - Response code indicating that the pharmacy dispensing the current drug is the same as the pharmacy dispensing the conflicting drug. 2 = Other Pharmacy in Same Chain - Code indicating the pharmacy dispensing the drug is in the same chain as the pharmacy dispensing the conflicting drug. 3 = Other Pharmacy - Code indicating the pharmacy of the current drug is not the same as the pharmacy of the conflicting drug.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
53Ø-FU	PREVIOUS DATE OF FILL	CCYYMMDD	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used.
531-FV	QUANTITY OF PREVIOUS FILL		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used.
533-FX	OTHER PRESCRIBER INDICATOR	Ø = Not Specified 1 = Same Prescriber - Response code indicating the prescriber of the current drug is the same as the prescriber of the conflicting drug. 2 = Other Prescriber – Code indicating the prescriber of the current drug is not the same as the prescriber of the conflicting drug.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.

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

1.1.1 CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

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

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

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is situational	X	Segment sent if required for reject clarification

Response Message Segment	Response Message Segment Identification (111-AM) = "20"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE	Text Message	RW	Required if text is needed for clarification or detail. Variable length is from 1-200 characters.

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

Response Insurance Segment	Response Insurance Segment Identification (111-AM) = "25"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
301-C1	GROUP ID		R	Used to identify the actual group ID used during adjudication.
524-FO	PLAN ID		R	Used to identify the actual plan ID used during adjudication.

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

Response Status Segment	Response Status Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER	17-digit FHCP TCN	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR			<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.

Response Status Segment Segment Identification (111-AM) = "21"				Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3	?	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used or is Field 526-FQ preferred.
55Ø-8F	HELP DESK PHONE NUMBER	ACS Help DESK # 1-800-365-4944		<i>If we previously returned Help Desk number in FQ, we are supposed to return it here instead</i>

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

Response Claim Segment Segment Identification (111-AM) = "22"				Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	<i>Imp Guide:</i> For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is situational	X	

Response DUR/PPS Segment Segment Identification (111-AM) = "24"				Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE		RW	<i>Imp Guide:</i> Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE	Blank = Not Specified 1 = Major - Code indicating that an event, transaction, etc. is of the highest importance; action required to prevent adverse drug event. 2 = Moderate – Code indicating that an event, transaction, etc. is of mid-level significance; requires thoughtful review before prescribing/dispensing the medication. Risk vs. benefit should be evaluated. 3 = Minor – Code indicating a non-life threatening, annoying, or now-well-documented effect which may or may not require a change in drug therapy. 9 = Undetermined - value to describe a professional service with variable or unknown severity.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill Accepted/Rejected
529-FT	OTHER PHARMACY INDICATOR	<p>Ø = Not Specified</p> <p>1 = Your Pharmacy - Response code indicating that the pharmacy dispensing the current drug is the same as the pharmacy dispensing the conflicting drug.</p> <p>2 = Other Pharmacy in Same Chain - Code indicating the pharmacy dispensing the drug is in the same chain as the pharmacy dispensing the conflicting drug.</p> <p>3 = Other Pharmacy - Code indicating the pharmacy of the current drug is not the same as the pharmacy of the conflicting drug.</p>	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
53Ø-FU	PREVIOUS DATE OF FILL	CCYYMMDD	R	<p><i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.</p> <p>Required if Quantity of Previous Fill (531-FV) is used.</p>
531-FV	QUANTITY OF PREVIOUS FILL		R	<p><i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.</p> <p>Required if Previous Date Of Fill (53Ø-FU) is used.</p>
532-FW	DATABASE INDICATOR	1 = First DataBank – a drug database company	?	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR	<p>Ø = Not Specified</p> <p>1 = Same Prescriber - Response code indicating the prescriber of the current drug is the same as the prescriber of the conflicting drug.</p> <p>2 = Other Prescriber – Code indicating the prescriber of the current drug is not the same as the prescriber of the conflicting drug.</p>	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.

1.1.2 CLAIM BILLING/CLAIM REBILL REJECTED/REJECTED RESPONSE

CLAIM BILLING/CLAIM REBILL REJECTED/REJECTED RESPONSE

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

	Response Transaction Header Segment			Claim Billing/Claim Rebill Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	

Response Transaction Header Segment				Claim Billing/Claim Rebill Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
501-F1	HEADER RESPONSE STATUS	R = Rejected	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, Payer Situation
This Segment is situational	X	Segment sent if required for reject clarification

Response Message Segment Segment Identification (111-AM) = "20"				Claim Billing/Claim Rebill Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE	Text Message	RW	Required if text is needed for clarification or detail. Variable length is from 1-200 characters.

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

Response Status Segment Segment Identification (111-AM) = "21"				Claim Billing/Claim Rebill Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER	17-digit OH TCN	RW	Imp Guide: Required if needed to identify the transaction.
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	Imp Guide: Required if a repeating field is in error, to identify repeating field occurrence.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Imp Guide: Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	Imp Guide: Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Imp Guide: Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	Imp Guide: Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03		Imp Guide: Required if Help Desk Phone Number (550-8F) is used or is Field 526-FQ preferred.
550-8F	HELP DESK PHONE NUMBER	ACS HELP DESK # 1-800-365-4944		If we previously returned Help Desk number in FQ, we are supposed to return it here instead

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

Additional Claim Information

- **M = Mandatory per the NCPDP Version 5.1 Claim Format Standard. These fields must be populated in order for the claim to be processed.**
- **R = Required above the Standard. These data fields must also be populated in order to have the claim processed.**
- **RW = Required When. These fields depend on other claim information or eligibility information to determine if they are required.**
- **ACS POS Help Desk: 800-365-4944**

DUR Codes

Reason for Service Codes (439-E4): DUR Conflict Codes

Code	Meaning	Code	Meaning
AT	Additive Toxicity	LD	Low Dose Alert
CH	Call Help Desk	LR	Under Use Precaution
DA	Drug Allergy Alert	MC	Drug Disease Precaution
DC	Inferred Drug Disease Precaution	MN	Insufficient Duration Alert

DD	Drug-Drug Interaction	MX	Excessive Duration Alert
DF	Drug Food Interaction	OH	Alcohol Precaution
DI	Drug Incombatability	PA	Drug Age Precaution
DL	Drug Lab Conflict	PG	Drug Pregnancy Alert
DS	Tobacco Use Precaution	PR	Prior Adverse Drug Reaction
ER	Over Use Conflict	SE	Side Effect Alert
HD	High Dose Alert	SX	Drug Gender Alert
IC	Iatrogenic Condition Alert	TD	Therapeutic Duplication
ID	Ingredient Duplication		

Professional Service Codes (440-E5): Intervention Codes

Code	Meaning	Code	Meaning
MØ	Prescriber Consulted - MD Interface	RØ	Pharmacist Consulted Other Source - Pharmacist reviewed
PØ	Patient Consulted - patient interaction		

Result of Service Codes (441-E6): Intervention Codes

Code	Meaning	Code	Meaning
1A	Filled As Is – False Positive	1F	Filled – Different Quantity
1B	Filled Prescription As Is	1G	Filled after prescriber approval
1C	Filled With Different Dose	2A	Prescription Not Filled - Code indicating a cognitive service
1D	Filled With Different Directions	2B	Not Filled, Directions Clarified