

Maryland AIDS Drug Assistance Program MADAP

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

GENERAL INFORMATION

Payer Name: Maryland Medical Assistance Program		Date: September 19, 2011
Plan Name/Group Name: Maryland AIDS Drug Assistance Program (MADAP)	BIN: 610084	PCN: DRAPPROD = Production
Plan Name/Group Name: Maryland AIDS Drug Assistance Program (MADAP) (test)	BIN: 610084	PCN: DRAPACCP = Test (after 1/1/2012) PCN: DRAPDV5S = Test (thru 12/31/2011 for D.0)
Processor: ACS, A Xerox Company		
Effective as of: January 1, 2012		NCPDP Telecommunication Standard Version/Release #: D.0
NCPDP Data Dictionary Version Date: Date of Publication		NCPDP External Code List Version Date: Date of Publication
Contact/Information Source: Other references such as Provider Manuals, Payer phone number, web site, etc.		
Certification Testing Window: Certification Testing Dates		
Certification Contact Information: Certification phone number and information		
Provider Relations Help Desk Info: 800-932-3918		
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 If Situational, Payer Situation
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 NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill Payer Situation
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	DRAPPROD = Production DRAPDV5S = D.0 Test DRAPACCP = Test	M	Use PCN DRAPDV5S for D.0 Testing through 12/31/2011
109-A9	TRANSACTION COUNT	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	

Transaction Header Segment			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
202-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider Identifier (NPI)	M	
201-B1	SERVICE PROVIDER ID	NPI Number	M	
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 Identification (111-AM) = "Ø4"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID	Recipient's MADAP ID Number	M	11 character number
301-C1	GROUP ID	MADAP	R	
306-C6	Patient Relationship Code	1 = Cardholder	R	

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

Patient Segment Identification (111-AM) = "Ø1"			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	Ø = Not Specified 1 = Male 2 = Female	R	
310-CA	PATIENT FIRST NAME		R	First 3 characters used for verification
311-CB	PATIENT LAST NAME		R	First 5 characters used for verification
384-4X	PATIENT RESIDENCE	Ø = Not specified 3 = Nursing Facility 11 = Hospice	RW	Enter value '3' or '11' to indicate the patient is in a LTC setting or hospice

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	
This payer supports partial fills	X	

Claim Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Rx Number assigned by the pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code	M	
407-D7	PRODUCT/SERVICE ID	National Drug Code (NDC)	M	
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER	Rx number of the associated partial fill claim	RW	Required for the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C").
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	Used when submitting a claim for a partial fill	RW	Date of the Associated Prescription/Service Reference Number.
442-E7	QUANTITY DISPENSED	Metric Decimal Quantity	R	
403-D3	FILL NUMBER	Ø = Original Dispensing 1-99 = Refill number	R	
405-D5	DAYS SUPPLY		R	
406-D6	COMPOUND CODE	1 = Not a compound 2 = Compound	R	'2' must be entered for submission of a multi line compound.

Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Ø = No Product Selection Indicated 1 = Substitution Not Allowed by Prescriber 5 = Substitution Allowed-Brand Drug Dispense as Generic 6 = Override	R	DAW 6 is used for brand name drugs that Maryland ADAP has designated as preferred over the generic
414-DE	DATE PRESCRIPTION WRITTEN	CCYYMMDD	R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	Required if Submission Clarification Code (42Ø-DK) is used.
42Ø-DK	SUBMISSION CLARIFICATION CODE	8 = Process compound for Approved Ingredients 99 = Other	RW	'8' is used when provider is willing to accept payment only for covered items of a multi line compound. '99' is used for the submission of an IV claim.
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	RW	Required when submitting a claim for a recipient who has other coverage.
429-DT	SPECIAL PACKAGING INDICATOR	Ø = Not specified 1 = Not Unit Dose 2 = Manufacturer Unit Dose 3 = Pharmacy Unit Dose	RW	'3' = Pharmacy Unit Dose Denies as non-covered at Retail.
418-DI	LEVEL OF SERVICE	3 = Emergency	RW	Required when submitting a claim for an emergency fill. Logic: NH recipients can receive 1 per month and they receive a 30-day supply. This is per Rx. Retail – 2 per script per month. Only for PDL denials.
461-EU	PRIOR AUTHORIZATION TYPE CODE	2 = Medical Certification 4 = Exemption from Copay and/or Coinsurance 5 = Exemption from Rx	RW	MD Medicaid only accepts 2, 4 and 5
343-HD	DISPENSING STATUS	P = Initial Fill C = Completion Fill	RW	Required for the partial fill or the completion of a partial fill.
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	Required when submitting a partial fill or the completion of a partial fill.
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	Required when submitting a partial fill or the completion of a partial fill.
995-E2	ROUTE OF ADMINISTRATION	SNOMED CT Value	RW	Required when the Rx is a compound

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	Required field in D.Ø.
412-DC	DISPENSING FEE SUBMITTED		RW	Required if needed to balance claim
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
43Ø-DU	GROSS AMOUNT DUE		R	

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
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)	R	
411-DB	PRESCRIBER ID	NPI Number	R	

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	X	

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 Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
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	99=Other	R	Required if Other Payer ID (34Ø-7C) is used. Required for this program 99=Other
34Ø-7C	OTHER PAYER ID		R	Third Party Payer ID
443-E8	OTHER PAYER DATE	CCYYMMDD	R	Required when there is payment or denial from another source.
341-HB	OTHER PAYER AMOUNT PAID COUNT		R	Required if Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø1=Delivery Ø2=Shipping Ø3=Postage Ø4=Administrative Ø5=Incentive Ø6=Cognitive Service Ø7=Drug Benefit Ø9=Compound Preparation Cost 1Ø=Sales Tax	R	Required when there is payment from another source
431-DV	OTHER PAYER AMOUNT PAID	S\$\$\$\$\$cc	R	Required if other payer has approved payment for some/all of the billing.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	R	Required if Other Payer Reject Code (472-6E) is used.
472-6E	OTHER PAYER REJECT CODE		R	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).
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	R	Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"				Claim Billing/Claim Rebill Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø1=Amount Applied to Periodic Deductible (517-FH) Ø2=Amount Attributed to Product Selection/Brand Drug (134-UK) Ø3=Amount Attributed to Sales Tax (523-FN) Ø4=Amount Exceeding Periodic Benefit Maximum (52Ø-FK) Ø5=Amount of Copay (518-FI) Ø6=Patient Pay Amount (5Ø5-F5) Ø7=Amount of Coinsurance (572-4U) Ø8=Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) Ø9=Amount Attributed to Health Plan Assistance Amount (129-UD) 1Ø=Amount Attributed to Provider Network Selection (133-UJ) 11=Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) 12=Amount Attributed to Coverage Gap (137-UP) 13=Amount Attributed to Processor Fee (571-NZ)	R	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		R	Required if OCC=2 or 4

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	R	Required when there is a conflict to resolve or reason for service to be explained (Max 9)
44Ø-E5	PROFESSIONAL SERVICE CODE	See Attached list of valid Values	R	Required when there is a professional service to be identified (Max 9)
441-E6	RESULT OF SERVICE CODE	See Attached list of valid Values	R	Required when There is a result of service to be Submitted (Max = 9).

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

Compound Segment Segment Identification (111-AM) = "10"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	01=Capsule 02=Ointment 03=Cream 04=Suppository 05=Powder 06=Emulsion 07=Liquid 10=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	03= National Drug Code (NDC)	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	

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

Facility Segment Segment Identification (111-AM) = "15"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
336-8C	FACILITY ID	Maryland assigned 9-character Facility ID number	RW	Required when Patient is in a Hospice or NH/LTC setting for validation of Patient Residence. Patient Residence field must also be populated.

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

Additional Claim Information

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	PE	Patient Education/Instruction
PØ	Patient Consulted - patient interaction	RØ	Pharmacist Consulted Other Source - Pharmacist reviewed

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

Code	Meaning	Code	Meaning
1A	Filled As Is – False Positive	1D	Filled With Different Directions
1B	Filled Prescription As Is	1F	Filled – Different Quantity
1C	Filled With Different Dose	1G	Filled after prescriber approval

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: Maryland Medical Assistance Program	Date: January 1, 2012	
Plan Name/Group Name: Maryland AIDS Drug Assistance Program (MADAP)	BIN: 610084	PCN: DRAPPROD = Production
Plan Name/Group Name: Maryland AIDS Drug Assistance Program (MADAP) - test	BIN: 610084	PCN: DRAPACCP = Test (after 1/1/2012) PCN: DRAPDV5S (thru 12/31/2011 for D.Ø testing)

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

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

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <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	X	Segment sent if required for clarification

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.

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

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 TCN	R	
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	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) If Situational, Payer Situation
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

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

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) Payer Situation
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID		R	
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		R	Populated with zeros
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	Required if Ingredient Cost Paid (506-F6) is greater than zero (Ø).
514-FE	REMAINING BENEFIT AMOUNT		R	Populated with zeros.
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		R	Populated with zeros.
518-FI	AMOUNT OF COPAY		R	Patient Copay
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		R	Populated with zeros.

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i>
This Segment is situational	X	Sent to provide information about DUR conflicts

Field #	Response DUR/PPS Segment Identification (111-AM) = "24"	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) Payer Situation
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE		RW	Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE		RW	Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR		RW	Required if needed to supply additional information for the utilization conflict.
530-FU	PREVIOUS DATE OF FILL	CCYYMMDD	RW	Required if needed to supply additional information for the utilization conflict.
531-FV	QUANTITY OF PREVIOUS FILL		RW	Required if needed to supply additional information for the utilization conflict.
532-FW	DATABASE INDICATOR	1 = First DataBank – a drug database company	RW	Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR		RW	Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE		RW	Required if needed to supply additional information for the utilization conflict.

CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

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

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

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

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

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 Segment Identification (111-AM) = "25"			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
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 <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

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

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	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 DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected <i>If Situational, Payer Situation</i>
This Segment is situational	X	

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill Accepted/Rejected
<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	Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE		RW	Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE		RW	Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR		RW	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
530-FU	PREVIOUS DATE OF FILL	CCYYMMDD	RW	Required if needed to supply additional information for the utilization conflict.
531-FV	QUANTITY OF PREVIOUS FILL		RW	Required if needed to supply additional information for the utilization conflict.
532-FW	DATABASE INDICATOR	1 = First DataBank – a drug database company	RW	Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR		RW	Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE		RW	Required if needed to supply additional information for the utilization conflict.

1.1.1 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
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	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.

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 TCN	RW	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	Required if a repeating field is in error, to identify repeating field occurrence.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Required if Additional Message Information (526-FQ) is used.

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	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.

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