



California Department of Public Health, Office of AIDS, Pre-Exposure Prophylaxis Assistance Program (PrEP-AP), (CDPH/OA/PrEP-AP) NCPDP D.0 Payer Specifications

October 10, 2022

Claim Billing/Claim Re-Bill Payer Sheet

****Start of Request Claim Billing/Claim Re-Bill (B1/B3) Payer Sheet****

General Information

Payer Name: Prime Therapeutics Management	
Plan Name/Group Name: California Department of Public Health, Office of AIDS, Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) (CDPH/OA/PrEP-AP)	BIN: 018786 NEW!
	PCN: PrEP Medicare: PREP NEW! PrEP Non-Medicare: 227737 NEW!
Processor: Prime Therapeutics Management	
Effective as of: 02/15/2018	NCPDP Telecommunication Standard Version/Release #: D.0
NCPDP Data Dictionary Version Date: October 2015	NCPDP External Code List Version Date: October 2015
Contact/Information Source: Girija Karri (GKarri@Magellanhealth.com)	
Certification Testing Window: January 22 – February 9, 2018	
Certification Contact Information: Girija Karri (GKarri@Magellanhealth.com)	
Provider Relations Help Desk Info: 1-888-829-5373	
Other versions supported: No	

Other Transactions Supported

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

Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal
B3	Claim Re-Bill

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 Re-Bill transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

Claim Billing/Claim Re-Bill Transaction

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

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

Transaction Header Segment		Claim Billing/Claim Re-Bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN NUMBER	018786	M	NEW!
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE		M	
104-A4	PROCESSOR CONTROL NUMBER	PrEP Medicare: PREP NEW! PrEP Non-Medicare: 227737 NEW!	M	NEW!

Transaction Header Segment		Claim Billing/Claim Re-Bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
109-A9	TRANSACTION COUNT		M	One transaction for B2 or compound claim; Four allowed for B1 or B3
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = NPI	M	
201-B1	Service Provider ID		M	
401-D1	Date of Service		M	
110-AK	Software Vendor/Certification ID	This will be provided by the provider's software vender	M	Required when vendor certification is required by Prime Therapeutics Management– otherwise submit all zeroes

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

Insurance Segment Segment Identification (111-AM) = "04"		Claim Billing/Claim Re-Bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	See value as printed on the ID Card
301-C1	GROUP ID	RXCAPREP	R	
312-CC	CARDHOLDER FIRST NAME		R	
313-CD	CARDHOLDER LAST NAME		R	

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

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

Patient Segment Segment Identification (111-AM) = “Ø1”		Claim Billing/Claim Re-Bill		
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø5-C5	PATIENT GENDER CODE	<ul style="list-style-type: none"> • Ø = Not Specified • 1 = Male • 2 = Female 	R	
31Ø-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	
3Ø7-C7	PLACE OF SERVICE		RW	Required if this field could result in different coverage, pricing, or patient financial responsibility.
335-2C	PREGNANCY INDICATOR	<ul style="list-style-type: none"> • Blank = Not Specified • 1 = Not Pregnant • 2 = Pregnant 	RW	Required if the patient is known to be pregnant.
384-4X	PATIENT RESIDENCE		RW	Required if this field could result in different coverage, pricing, or patient financial responsibility.

Claim Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent	X	
This plan does not support partial fills	X	

Claim Segment Segment Identification (111-AM) = “Ø7”		Claim Billing/Claim Re-Bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	1= Rx Billing	M	For Transaction Code of “B1,” in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing).
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER		M	

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-Bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
436-E1	PRODUCT/SERVICE ID QUALIFIER	<ul style="list-style-type: none"> • ØØ = Not specified • Ø3 = National Drug Code (NDC) 	M	<ul style="list-style-type: none"> • ØØ must be submitted for compounds • Ø3 = National Drug Code (NDC)
4Ø7-D7	PRODUCT/SERVICE ID		M	<ul style="list-style-type: none"> • NDC for non-compound claims • "Ø" for compound claims
442-E7	QUANTITY DISPENSED		R	
460-ET	QUANTITY PRESCRIBED		RW	<i>Imp Guide:</i> Required when a transmission is for a Scheduled II drug as defined in 21 CFR 1308.12 and per CMS-0055-F (Compliance Date 09/21/2020. Refer to the <i>Version D.0 Editorial Document</i>).
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	<ul style="list-style-type: none"> • 1 = Not a Compound • 2 = Compound 	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED	<ul style="list-style-type: none"> • Ø = No refills authorized • 1–99 = Authorized Refill number 	R	
419-DJ	PRESCRIPTION ORIGIN CODE	<ul style="list-style-type: none"> • 1 = Written • 2 = Telephone • 3 = Electronic • 4 = Facsimile • 5 = Pharmacy 	R	

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-Bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
354-NX	SUBMISSION CLARIFICATION CODE COUNT		RW	Required if Submission Clarification Code (42Ø-DK) is used.
42Ø-DK	SUBMISSION CLARIFICATION CODE		RW	
3Ø8-C8	OTHER COVERAGE CODE	<ul style="list-style-type: none"> • Ø = Not Specified by patient • 1 = No Other Coverage Identified • 8=Claim billing for copay 	RW	Required when submitting a claim for recipient who has other coverage
6ØØ-28	UNIT OF MEASURE	<ul style="list-style-type: none"> • Values: • EA = Each • GM = Grams • ML = Milliliters 	R	NEW!
418-DI	LEVEL OF SERVICE		RW	
461-EU	PRIOR AUTHORIZATION TYPE CODE		RW	
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	
995-E2	ROUTE OF ADMINISTRATION	SNOMED CT Values	RW	Required when submitting compound claims. Compounds are not normally covered. Exceptions will be made when necessary.
996-G1	COMPOUND TYPE		RW	Required if specified in trading partner agreement.
147-U7	PHARMACY SERVICE TYPE		RW	Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer.

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

Pricing Segment Segment Identification (111-AM) = "11"		Claim Billing/Claim Re-Bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		RW	Required if its value has an effect on the Gross Amount Due (430-DU) calculation.
433-DX	PATIENT PAID AMOUNT SUBMITTED		RW	NOT REQUIRED; DO NOT SEND.
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	Required if its value has an effect on the Gross Amount Due (430-DU) calculation.
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3	RW	Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		RW	Required if Other Amount Claimed Submitted (480-H9) is used.
480-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	Required if its value has an effect on the Gross Amount Due (430-DU) calculation.
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		RW	Required if its value has an effect on the Gross Amount Due (430-DU) calculation.
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
430-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION			Required if needed for receiver claim/encounter adjudication.

Provider Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is not sent	X	

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

Prescriber Segment Identification (111-AM) = "Ø3"		Claim Billing/Claim Re-Bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = NPI	R	
411-DB	PRESCRIBER ID	Prescriber's individual NPI	R	Must submit valid NPI
427-DR	PRESCRIBER LAST NAME		RW	Required when the Prescriber ID (411-DB) is not known.
364-2J	PRESCRIBER FIRST NAME		RW	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.

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

Coordination of Benefits/Other Payments Segment Identification (111-AM) = "Ø5"		Claim Billing Scenario 2 – Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	Coordination of Benefits/Other Payments Count	Maximum count of 9.	M	
338-5C	Other Payer Coverage Type	All values supported.	M	
339-6C	OTHER PAYER ID QUALIFIER		RW	Imp Guide: Required if Other Payer ID (34Ø-7C) is used.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing Scenario 2 – Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
34Ø-7C	OTHER PAYER ID		RW	Imp Guide: Required if identification of the Other Payer is necessary for claim/encounter adjudication.
443-E8	OTHER PAYER DATE		RW	Imp Guide: Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	Imp Guide: Required if Other Payer Reject Code (472-6E) is used.
472-6E	OTHER PAYER REJECT CODE		RW	Imp Guide: 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.	RW	Imp Guide: Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		RW	Imp Guide: Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	Imp Guide: Required if necessary for patient financial responsibility only billing.

DUR/PPS Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Submitted if required to affect outcome of claim related to DUR intervention.

DUR/PPS Segment Segment Identification (111-AM) = “Ø8”		Claim Billing/Claim Re-Bill		
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	Allowed values: <ul style="list-style-type: none"> • DD = Drug-Drug Interaction • ID = Ingredient Duplication 	RW***	<ul style="list-style-type: none"> • Required when there is a conflict to resolve or reason for service to be explained (Max 9) • Code identifying the type of utilization conflict detected or the reason for the pharmacist’s professional service. Required when needed to communicate DUR information
44Ø-E5	PROFESSIONAL SERVICE CODE	<ul style="list-style-type: none"> • Allowed values: • MØ = Prescriber consulted • PØ = Patient consulted • RØ = Pharmacist consulted other source • ØØ = No Intervention • CC = Coordination of Care • PE = Patient Education • PH = Patient Medication History 	RW***	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Allowed values: • 1A = Filled As Is, False Positive • 1B = Filled Prescription As Is • 1C = Filled, With Different Dose 	RW***	<ul style="list-style-type: none"> • 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

DUR/PPS Segment Identification (111-AM) = "Ø8"		Claim Billing/Claim Re-Bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		<ul style="list-style-type: none"> • 1D = Filled, With Different Directions • 1F = Filled, With Different Quantity • 1G = Filled, With Prescriber Approval • 2A = Prescription not filled • 3B = Recommendation Not Accepted • 3C = Discontinued Drug 		
474-8E	DUR/PPS LEVEL OF EFFORT		RW	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.

Compound Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is situational	X	Compounds are not covered for this program.

Clinical Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Submitted if the clinical detail will affect the outcome of claims processing.

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-Bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5	RW	Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.
492-WE	DIAGNOSIS CODE QUALIFIER		RW***	Required if Diagnosis Code (424-DO) is used.
424-DO	DIAGNOSIS CODE		RW***	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.

****End of Request Claim Billing/Claim Re-Bill (B1/B3) Payer Sheet****

Response Claim Billing/Claim Re-Bill Payer Sheet

Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid) Response

****Start of Response Claim Billing/Claim Re-Bill (B1/B3) Payer Sheet****

General Information

Payer Name: Prime Therapeutics State Government Solutions	Revision Date: 07/24/2020	
Plan Name/Group Name: California Department of Public Health, Office of AIDS, Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) (CDPH/OA/PrEP-AP)	BIN: 018786 NEW!	PCN: PrEP Medicare: PREP NEW! PrEP Non-Medicare: 227737 NEW!

Claim Billing/Claim Re-Bill PAID (or Duplicate of PAID) Response

The following lists the segments and fields in a Claim Billing or Claim Re-Bill 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 Re-Bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Response Transaction Header Segment		Claim Billing/Claim Re-Bill 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	

Response Transaction Header Segment		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	<i>Sent if additional information is available from the payer/processor.</i>

Response Message Segment Identification (111-AM) = "2Ø"		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
5Ø4-F4	MESSAGE		R	Required if text is needed for clarification or detail.

Response Insurance Segment Questions	Check	Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Insurance Segment Identification (111-AM) = "25"		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
524-FO	PLAN ID		RW	
3Ø1-C1	GROUP ID		RW	
3Ø2-C2	CARDHOLDER ID		RW	

Response Patient Segment Questions	Check	Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		

Response Patient Segment Questions		Check	Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation		
This Segment is situational		X			
Response Patient Segment Segment Identification (111-AM) = "29"		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation	
310-CA	PATIENT FIRST NAME		RW	Required if known.	
311-CB	PATIENT LAST NAME		RW	Required if known.	
304-C4	DATE OF BIRTH		RW	Required if known.	
Response Status Segment Questions		Check	Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation		
This Segment is always sent		X			
Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation	
112-AN	TRANSACTION RESPONSE STATUS	<ul style="list-style-type: none"> P = Paid D = Duplicate of Paid 	M		
503-F3	AUTHORIZATION NUMBER		RW	Required if needed to identify the transaction.	
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.	RW	Required if Approved Message Code (548-6F) is used.	
548-6F	APPROVED MESSAGE CODE		RW	Required if Approved Message Code Count (547-5F) is used.	
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.	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER		RW	Required if needed to provide a support telephone number to the receiver.

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

Response Claim Segment Segment Identification (111-AM) = "22"		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

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

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID		RW	Required if this value is used to arrive at the final reimbursement.
521-FL	INCENTIVE AMOUNT PAID		RW	Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø).
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	RW	Required if Other Amount Paid (565-J4) is used.
564-J3	OTHER AMOUNT PAID QUALIFIER		RW	Required if Other Amount Paid (565-J4) is used.
565-J4	OTHER AMOUNT PAID		RW	Required if Other Amount Claimed Submitted (480-H9) 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	<ul style="list-style-type: none"> Required if Ingredient Cost Paid (506-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing.
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT		RW	Provided for informational purposes only.
513-FD	REMAINING DEDUCTIBLE AMOUNT		RW	Provided for informational purposes only.
514-FE	REMAINING BENEFIT AMOUNT		RW	Provided for informational purposes only.

Response Pricing Segment Segment Identification (111-AM) = “23”		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	Required if Patient Pay Amount (505-F5) includes deductible
518-FI	AMOUNT OF COPAY		RW	Required if Patient Pay Amount (505-F5) includes co-pay as patient financial responsibility.
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		RW	Required if Patient Pay Amount (505-F5) includes amount exceeding periodic benefit maximum.
346-HH	BASIS OF CALCULATION-DISPENSING FEE		RW	
347-HJ	BASIS OF CALCULATION-COPAY		RW	
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE		RW	
574-2Y	AMOUNT OF COINSURANCE		RW	
572-4U	AMOUNT OF COINSURANCE		RW	Required if Patient Pay Amount (505-F5) includes coinsurance as patient financial responsibility.
573-4V	BASIS OF CALCULATION-COINSURANCE		RW	
392-MU	BENEFIT STAGE COUNT		RW	
393-MV	BENEFIT STAGE QUALIFIER		RW	
394-MW	BENEFIT STAGE AMOUNT		RW	
577-G3	ESTIMATED GENERIC SAVINGS		RW	

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
128-UC	SPENDING ACCOUNT AMOUNT REMAINING		RW	This dollar amount will be provided, if known, to the receiver when the transaction had spending account dollars reported as part of the patient pay amount.
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION		RW	Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG		RW	Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a Brand drug.
148-U8	INGREDIENT COST CONTRACTED/REIMBURS ABLE AMOUNT		RW	
149-U9	DISPENSE FEE CONTRACTED/REIMBURS ABLE AMOUNT		RW	

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Sent when DUR intervention is encountered during claim processing.

Response DUR/PPS Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	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		RW	Required if Quantity of Previous Fill (531-FV) is used.
531-FV	QUANTITY OF PREVIOUS FILL		RW	Required if Previous Date Of Fill (530-FU) is used.
532-FW	DATABASE INDICATOR		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.
570-NS	DUR ADDITIONAL TEXT		RW	Required if needed to supply additional information for the utilization conflict.

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Sent when Other Health Insurance (OHI) is encountered during claims processing.

Response Coordination of Benefits/Other Payers Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		RW	Required if Other Payer ID (34Ø-7C) is used.
34Ø-7C	OTHER PAYER ID		RW	Required if other insurance information is available for coordination of benefits.
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	Required if other insurance information is available for coordination of benefits.
356-NU	OTHER PAYER CARDHOLDER ID		RW	Required if other insurance information is available for coordination of benefits.
992-MJ	OTHER PAYER GROUP ID		RW	Required if other insurance information is available for coordination of benefits.
142-UV	OTHER PAYER PERSON CODE		RW	Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer.
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	Required if needed to provide a support telephone number of the other payer to the receiver.
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer.

Response Coordination of Benefits/Other Payers Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-Bill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		RW	Required when other coverage is known which is after the Date of Service submitted.
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		RW	Required when other coverage is known which is after the Date of Service submitted.

Claim Billing/Claim Re-Bill Accepted/Rejected Response

Response Transaction Header Segment Questions		Check	Claim Billing/Claim Re-Bill Accepted/Rejected If Situational, Payer Situation		
This Segment is always sent		X			
Response Transaction Header Segment		Claim Billing/Claim Re-Bill Accepted/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		
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M		
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M		
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M		
4Ø1-D1	DATE OF SERVICE	Same value as in request	M		
Response Message Segment Questions		Check	Claim Billing/Claim Re-Bill Accepted/Rejected If Situational, Payer Situation		
This Segment is always sent					
This Segment is situational		X			
Response Message Segment Identification (111-AM) = "2Ø"		Claim Billing/Claim Re-Bill Accepted/Rejected			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation	
5Ø4-F4	MESSAGE		RW	Required if text is needed for clarification or detail.	

Response Insurance Segment Questions	Check	Claim Billing/Claim Re-Bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Response Insurance Segment Identification (111-AM) = "25"		Claim Billing/Claim Re-Bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
301-C1	GROUP ID		R	Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available.
524-FO	PLAN ID		RW	Required if needed to identify the actual plan parameters, benefit, or coverage criteria, when available.
568-J7	PAYER ID QUALIFIER		RW	Required if Payer ID (569-J8) is used.
569-J8	PAYER ID		RW	Required to identify the ID of the payer responding.
302-C2	CARDHOLDER ID		RW	Required if the identification to be used in future transactions is different than what was submitted on the request.

Response Patient Segment Questions	Check	Claim Billing/Claim Re-Bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Sent when known by plan

Response Patient Segment Identification (111-AM) = "29"		Claim Billing/Claim Re-Bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME		RW	Required if known.
311-CB	PATIENT LAST NAME		RW	Required if known.

Response Patient Segment Segment Identification (111-AM) = “29”		Claim Billing/Claim Re-Bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
304-C4	DATE OF BIRTH		RW	Required if known.
Response Status Segment Questions		Check	Claim Billing/Claim Re-Bill Accepted/Rejected If Situational, Payer Situation	
This Segment is always sent		X		
Response Status Segment Segment Identification (111-AM) = “21”		Claim Billing/Claim Re-Bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER			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.
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	Required if Help Desk Phone Number (550-8F) is used.

Response Status Segment Segment Identification (111-AM) = “21”		Claim Billing/Claim Re-Bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
55Ø-8F	HELP DESK PHONE NUMBER		RW	Required if needed to provide a support telephone number to the receiver.
987-MA	URL		RW	Provided for informational purposes only to relay health care communications via the Internet.

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

Response Claim Segment Segment Identification (111-AM) = “22”		Claim Billing/Claim Re-Bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER		M	1 = RxBilling
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Re-Bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Sent when DUR intervention is encountered during claim adjudication.

Response DUR/PPS Segment Segment Identification (111-AM) = “24”		Claim Billing/Claim Re-Bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	Required if Reason For Service Code (439-E4) is used.

Response DUR/PPS Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-Bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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		RW	Required if Quantity of Previous Fill (531-FV) is used.
531-FV	QUANTITY OF PREVIOUS FILL		RW	Required if Previous Date Of Fill (530-FU) is used.
532-FW	DATABASE INDICATOR		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.
570-NS	DUR ADDITIONAL TEXT		RW	Required if needed to supply additional information for the utilization conflict.

Response Prior Authorization Segment Questions	Check	Claim Billing/Claim Re-Bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Sent when claim adjudication outcome requires subsequent PA number for payment

Response Prior Authorization Segment Segment Identification (111-AM) = "26"		Claim Billing/Claim Re-Bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
498-PY	PRIOR AUTHORIZATION NUMBER-ASSIGNED		RW	Required when the receiver must submit this Prior Authorization Number in order to receive payment for the claim.

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Re-Bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Sent when Other Health Insurance (OHI) is encountered during claim processing.

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-Bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		RW	Required if Other Payer ID (340-7C) is used.
340-7C	OTHER PAYER ID		RW	Required if other insurance information is available for coordination of benefits.
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	Required if other insurance information is available for coordination of benefits.
356-NU	OTHER PAYER CARDHOLDER ID		RW	Required if other insurance information is available for coordination of benefits.
992-MJ	OTHER PAYER GROUP ID		RW	Required if other insurance information is available for coordination of benefits.

Response Coordination of Benefits/Other Payers Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-Bill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
142-UV	OTHER PAYER PERSON CODE		RW	Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer.
127-UB	Other Payer Help Desk Phone Number		RW	Required if needed to provide a support telephone number of the other payer to the receiver.
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer.
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		RW	Required when other coverage is known which is after the Date of Service submitted.
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		RW	Required when other coverage is known which is after the Date of Service submitted.

Claim Billing/Claim Re-Bill Rejected/Rejected Response

Response Transaction Header Segment Questions		Check	Claim Billing/Claim Re-Bill Rejected/Rejected If Situational, Payer Situation		
This Segment is always sent		X			
Response Transaction Header Segment		Claim Billing/Claim Re-Bill 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		
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M		
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M		
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M		
4Ø1-D1	DATE OF SERVICE	Same value as in request	M		
Response Message Segment Questions		Check	Claim Billing/Claim Re-Bill Rejected/Rejected If Situational, Payer Situation		
This Segment is always sent					
This Segment is situational		X			
Response Message Segment Identification (111-AM) = "2Ø"		Claim Billing/Claim Re-Bill Rejected/Rejected			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation	
5Ø4-F4	MESSAGE		RW	Required if text is needed for clarification or detail.	

Response Status Segment Questions		Check	Claim Billing/Claim Re-Bill Rejected/Rejected If Situational, Payer Situation	
This Segment is always sent		X		
Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-Bill Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		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.
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	Required if Help Desk Phone Number (550-8F) is used.
550-8F	HELP DESK PHONE NUMBER		RW	Required if needed to provide a support telephone number to the receiver.

NCPDP Version D.0 Claim Reversal

Request Claim Reversal Payer Sheet

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

General Information

Payer Name: Prime Therapeutics Management		
Plan Name/Group Name: California Department of Public Health, Office of AIDS, Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) (CDPH/OA/PrEP-AP)	BIN: 018786 NEW!	PCN: PrEP Medicare: PREP NEW! PrEP Non-Medicare: 227737 NEW!

Claim Reversal Transaction

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

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

Transaction Header Segment		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN NUMBER	018786	M	NEW!
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	
104-A4	PROCESSOR CONTROL NUMBER	PrEP Medicare: PREP NEW! PrEP Non-Medicare: 227737 NEW!	M	NEW!
109-A9	TRANSACTION COUNT		M	

Transaction Header Segment		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = NPI	M	
201-B1	SERVICE PROVIDER ID	NPI Number	M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	This will be provided by the provider's software vendor	M	If no number is supplied, populate with zeros

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

Insurance Segment Identification (111-AM) = "04"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	
301-C1	GROUP ID		RW	Required if needed to match the reversal to the original billing transaction.

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

Claim Segment Identification (111-AM) = "07"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER		M	
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	

Claim Segment Identification (111-AM) = "07"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
407-D7	PRODUCT/SERVICE ID		M	
403-D3	FILL NUMBER	<ul style="list-style-type: none"> Ø = Original Dispensing 1–99 = Number of refills 	R	Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (402-D2) occur on the same day.
308-C8	OTHER COVERAGE CODE		RW	Required if needed by receiver to match the claim that is being reversed.

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

Pricing Segment Identification (111-AM) = "11"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	Required if this field could result in contractually agreed upon payment.
430-DU	GROSS AMOUNT DUE		RW	Required if this field could result in contractually agreed upon payment.

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

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
339-6C	OTHER PAYER ID QUALIFIER		RW	Required if Other Payer ID (Field # 34Ø-7C) is used
34Ø-7C	OTHER PAYER ID		RW	Required if COB segment is used
443-E8	OTHER PAYER DATE		RW	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.	RW	Required if Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER		RW	Required when there is payment from another source.
431-DV	OTHER PAYER AMOUNT PAID		RW	Required if other payer has approved payment for some/all of the billing.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW***	Required on all COB claims with Other Coverage Code of 3.
472-6E	OTHER PAYER REJECT CODE		RW	Required on all COB claims with Other Coverage Code of 3
353-NR	OTHER PAYER – PATIENT RESPONSIBILITY AMOUNT COUNT		R	Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø6 = Patient Pay Amount (5Ø5-F5)	R	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		R	Required OCC = 2 or 4
392-MU	BENEFIT STAGE COUNT	Maximum count of 4	RW	

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
393-MV	BENEFIT STAGE QUALIFER		RW	
394-MW	BENEFIT STAGE AMOUNT		RW	

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

Response Claim Reversal Payer Sheet

Claim Reversal Accepted/Approved Response

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

General Information

Payer Name: Prime Therapeutics State Government Solutions		
Plan Name/Group Name: California Department of Public Health, Office of AIDS, Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) (CDPH/OA/PrEP-AP)	BIN: 018786 NEW!	PCN: PrEP Medicare: PREP NEW! PrEP Non-Medicare: 227737 NEW!

Claim Reversal Accepted/Approved Response

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

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

Response Transaction Header Segment		Claim Reversal – Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B2	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider Identifier (NPI)	M	
201-B1	SERVICE PROVIDER ID	NPI Number	M	
401-D1	DATE OF SERVICE		M	

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

Response Message Segment Identification (111-AM) = “20”		Claim Reversal – Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE		RW	Required if text is needed for clarification or detail.

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

Response Status Segment Identification (111-AM) = “21”		Claim Reversal – Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	
503-F3	AUTHORIZATION NUMBER		RW	Required if needed to identify the transaction.
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.	RW	Required if Approved Message Code (548-6F) is used.
548-6F	APPROVED MESSAGE CODE		RW	Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity.
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.

Response Status Segment Segment Identification (111-AM) = “21”		Claim Reversal – Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER		RW	Required if needed to provide a support telephone number to the receiver.

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

Response Claim Segment Segment Identification (111-AM) = “22”		Claim Reversal – Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	For Transaction Code of “B2”, 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 Pricing Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Sent if reversal results in generation of pricing detail.

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

Claim Reversal Accepted/Rejected Response

Response Transaction Header Segment Questions		Check	Claim Reversal – Accepted/Rejected If Situational, Payer Situation		
This Segment is always sent		X			
Response Transaction Header Segment		Claim Reversal – Accepted/Rejected			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M		
1Ø3-A3	TRANSACTION CODE	B2	M		
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M		
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M		
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider Identifier (NPI)	M		
2Ø1-B1	SERVICE PROVIDER ID	NPI Number	M		
4Ø1-D1	DATE OF SERVICE		M		
Response Message Segment Questions		Check	Claim Reversal – Accepted/Rejected If Situational, Payer Situation		
This Segment is always sent					
This Segment is situational		X			
Response Message Segment Identification (111-AM) = "2Ø"		Claim Reversal – Accepted/Rejected			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation	
5Ø4-F4	MESSAGE		RW	Required if text is needed for clarification or detail.	
Response Status Segment Questions		Check	Claim Reversal – Accepted/Rejected If Situational, Payer Situation		
This Segment is always sent		X			

Response Status Segment Segment Identification (111-AM) = “21”		Claim Reversal – Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		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.
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	Required if Help Desk Phone Number (550-8F) is used.
550-8F	HELP DESK PHONE NUMBER		RW	Required if needed to provide a support telephone number to the receiver.

Response Claim Segment Questions		Check	Claim Reversal – Accepted/Rejected If Situational, Payer Situation		
This Segment is always sent		X			
Response Claim Segment Identification (111-AM) = “22”		Claim Reversal – Accepted/Rejected			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation	
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M		
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M		
Coordination of Benefits/Other Payments Segment Questions		Check	Claim Reversal If Situational, Payer Situation		
This Segment is always sent					
This Segment is situational		X			
Coordination of Benefits/Other Payments Segment Identification (111-AM) = “05”		Claim Reversal			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation	
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M		
338-5C	OTHER PAYER COVERAGE TYPE		M		

Claim Reversal Rejected/Rejected Response

Response Transaction Header Segment Questions		Check	Claim Reversal – Rejected/Rejected If Situational, Payer Situation		
This Segment is always sent		X			
Response Transaction Header Segment		Claim Reversal – Rejected/Rejected			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation	
102-A2	VERSION/RELEASE NUMBER	DØ	M		
103-A3	TRANSACTION CODE	B2	M		
109-A9	TRANSACTION COUNT	1 = One Occurrence	M		
501-F1	HEADER RESPONSE STATUS	R = Rejected	M		
202-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider Identifier	M		
201-B1	SERVICE PROVIDER ID	NPI Number	M		
401-D1	DATE OF SERVICE		M		
Response Message Segment Questions		Check	Claim Reversal – Rejected/Rejected If Situational, Payer Situation		
This Segment is always sent					
This Segment is situational		X			
Response Message Segment Identification (111-AM) = “2Ø”		Claim Reversal – Rejected/Rejected			
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation	
504-F4	MESSAGE		RW	<ul style="list-style-type: none"> • <i>Imp Guide</i>: Required if text is needed for clarification or detail. • Payer Requirement: Same as <i>Imp Guide</i> 	
Response Status Segment Questions		Check	Claim Reversal - Rejected/Rejected If Situational, Payer Situation		
This Segment is always sent		X			

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal – Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		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.
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.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	Required if Help Desk Phone Number (550-8F) is used.
550-8F	HELP DESK PHONE NUMBER		RW	Required if needed to provide a support telephone number to the receiver.

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

Revision History

Date	Name	Comments
02/15/2018	Implementation team	Initial creation
07/24/2020	Steven Giera	Added quantity prescribed field (# 460-ET) required for Schedule II drugs in Claim Segment Ø7
	Documentation Management team	Rebranded; reformatted; updated and standardized naming conventions; and added Revision History table
10/10/2022	Documentation Management team	Updated document to reference current company name.