WithMe Health Payer Sheet

(rev. 202209)

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WithMe Health Payer Sheet

Part I: General Information

Payer Name: WithMe Health, LLC **/ Navitus Health Solution**	**Date:** 1/1/2022
Plan/Group Name: WithMe Health, LLC	
Processor: NaviClaimRx	**Switch:**
Effective Date: 1/1/2022	**NCPDP Version/Release #:** D.0
Contact/Information Source: General website ***www.withmehealth.com***	
Pharmacy Network Contact Information: Name: Debbie Coates Email: debbie.coates@withmehealth.com Phone Number: 1-866-840-1877	
Pharmacy Network Contact Information: Name: Debbie Coates Email: debbie.coates@withmehealth.com Phone Number: 1-866-840-1877	
Other version supported: None	

Plan Name:	BIN:	PCN:
WithMe Health, LLC Groups	024789	WMHRX

Payer Usage Column	Value	Explanation
MANDATORY	**M**	The Field is mandatory for the segment in the designated transaction.
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated transaction.
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").
Optional	**O**	The field is optional for the segment in the designated transaction.

Part II: Request Claim Billing/Claim Rebill Segments

The following table lists the segments available in a Billing Transaction. The table also lists values as defined under NCPDP Version **D.0** for your reference. Other fields are required as noted:

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

Maximum Number of Transactions Supported per Transmission	1
What is the Submission Window? (Days from date filled/dispensed to date submitted)	Standard is 90 days, but can be plan specific.

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-Al	BIN Number	See Section **<Plan Name>** Above	M	
102-A2	Version/Release Number	D0	M	Version D.Ø
103-A3	Transaction Code	B1, B3	M	
104-A4	Processor Control Number	See Section **<Plan Name>** Above	M	
109-A9	Transaction Count	1	M	Max Number 1 transaction per transmission
202-B2	Service Provider ID Qualifier		M	01 = NPI
201-B1	Service Provider ID	NPI	M	Value for qualifier 202-B2
401-D1	Date of Service	CCYYMMDD	M	
110-AK	Software Vender/Certification ID		R	Use value for Switch's requirements. If submitting claim without a Switch, populate with blanks.

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	04	M	Insurance Segment
302-C2	Cardholder ID		M	Member's ID shown on card.
312-CC	Cardholder First Name		R	Required when necessary for state/federal/regulatory agency programs when the cardholder has a first name
313-CD	Cardholder Last Name		R	Required when necessary for state/federal/regulatory agency programs
303-C3	Person Code		R	Member Id person code within the family usually appears as two digits.
306-C6	Patient Relationship Code		R	Ø=Not Specified, 1=Cardholder, 2=Spouse, 3=Child, 4=Other
301-C1	Group ID		R	As Appears on Card

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	01	M	Patient Segment
304-C4	Date of Birth		R	CCYYMMDD
305-05	Patient Gender Code	1,2	R	1=Male, 2=Female
310-CA	Patient First Name		R	Member receiving the prescription name
311-CB	Patient Last Name		R	Member receiving the prescription last name.
307-C7	Place of Service		RW	Required when billing for patient in Long- Term Care setting: Ø=Not Specified, 1=Home, 2=Inter-Care, 3=Nursing Home, 4=Long Term/Extended Care, 5=Rest Home, 6=Boarding Home, 7=Skilled Care Facility, 8=Sub-Acute Care Facility, 9=Acute Care Facility, 1Ø=Outpatient, 11=Hospice

322-CM	Patient Street Address	0	O	Required for some federal programs or when submitting Tax.
323-CN	Patient City	0	O	Required for some federal programs or when submitting Tax.
324-CO	Patient State/Province	0	O	Required for some federal programs or when submitting Tax.
325-CP	Patient Zip/Postal Code	0	O	Required for some federal programs or when submitting Tax.
326-CQ	Patient Phone Number	0	O	Required for some federal programs or when submitting Tax.

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	07	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	01	M	1=Rx Billing Code
402-D2	Prescription/Service Reference Number		M	Prescription number, Rx Number Assigned by the pharmacy software
436-E1	Product/Service ID Qualifier	00-not specified 03-NDC	M	Use “00” for multi-ingredient compounds
407-D7	Product/Service ID		R	NDC of the product being dispensed If billing for a multi-ingredient prescription, Product/Service ID (4Ø7-D7) is zero (Ø)
422-E7	Quantity Dispensed		R	
403-D3	Fill Number		R	0=Original Dispensing 1-99=Refill Number
405-D5	Days Supply		R	
406-D6	Compound Code		R	1=Not a Compound 2=Compound
408-D8	Dispense as Written (DAW)		R	
414-DE	Date Prescription Written		R	CCYYMMDD
354-NX	Submission Clarification Code Count	Max of 3	O	Required when Submission Clarification Code (42Ø-DK) is used
420-DK	Submission Clarification Code		RW	Required if clarification is needed and value submitted is greater than zero (Ø). A claim is identified as being for Section 34ØB drugs using the Submission Clarification Code The field can contain multiple repetitions to indicate a myriad of situations related to the specific claim being billed. To indicate that a claim is billing for Section 34ØB drugs, the value of 2Ø is used.

308-C8	Other Coverage Code		RW	Required when communicating summation of other coverage information collected from other payers. See Customer Coverage below. **00** or **01**= Not a COB claim **02**= Other Coverage exists and payment has been collected **03**= Other Coverage Billed-claim not covered **04**=Other Coverage exists and no payment has been collected
995-E2	Route of Administration		R	
996-G1	Compound Type		RW	Required when Compound Code (406-D6)=2
460-ET	Quantity Prescribed		RW	Required when Product/Service ID (407-D7) is a schedule II drug as defined in 21 CFR 1308.12 and per CMS-0055-F *(Compliance Date 9/21/2020. Refer to the Version D.0 Editorial Document)*
418-DI	Level Of Service		RW	Required when requested by the processor
454-EK	Schedule Prescription Id Number		RW	Required when requested by the processor
461-EU	Prior Authorization Type Code		RW	Possible values to submit are from 1 to 7 according to NCPDP Guidelines.
462-EV	Prior Authorization Number Submitted		RW	
147-U7	Pharmacy Service Type		R	Required for plan benefit administration or when Mail Order / Specialty is submitting sales tax Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer

COB Customer Coverage	OCC Allowance
All Groups	OCC 2 & 4

Pricing Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	11	M	Pricing Segment
4O9-D9	Ingredient Cost Submitted		M	Ingredient cost submitted by the pharmacy software.
412-DC	Dispensing Fee Submitted		R	Dispensing fee cost submitted by the pharmacy software.
426-DQ	Usual & Customary Charge		M	Usual & customary charge calculated by the pharmacy software. This value usually is the amount charge by the pharmacy to the members at POS.
430-DU	Gross Amount Due		R	s
423-DN	Basis of Cost Determination		R	
438-E3	Incentive Amount Submitted		RW	Required when value has effect on Gross Amount Due (430-DU) calculation
478-H7	Other Amount Claimed Submitted Count	Max count of 3	RW	Required when Other Amount Claimed Amount Qualifier (479-H8) is submitted
479-H8	Other Amount Claimed Submitted Qualifier	01-Delivery Cost 02-Shipping Cost 03- Postage Cost 04- Administrative Cost 09- Compound preparation Cost Submitted	RW	Required when Other Amount Claimed (480-H9) is submitted
480-H9	Other Amount Claimed Submitted		RW	Required when value has effect on Gross Amount Due (43O-DU) calculation
				Required when provider is claiming sales tax
482-GE	Percentage Sales Tax Amount Submitted		RW	Required when provider is claiming sales tax
483-HE	Percentage Sales Tax Rate Submitted		RW	Required when provider is claiming sales tax Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX)
484-JE	Percentage Sales Tax Basis Submitted		RW	Required when provider is claiming sales tax Required if needed to calculate Percentage Sales Tax

				Amount Paid (559-AX)

Pharmacy Provider Segment *	Check	Claim Billing/Claim Rebill
This Segment is always sent		
This Segment is situational		

Field#	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill
111-AM	Segment Identification	02	M	*Pharmacy Provider Segment*
465-EY	Provider ID Qualifier	01	R	Required if Provider ID (444-E9) is used.
444-E9	Provider ID	NPI	R	Required if necessary for state/federal/regulatory agency programs.

*This segment is required for Florida Workers' Compensation claims only.

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	
This Segment is situational		

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	03	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	01	R	
411-DB	Prescriber ID		R	Value for qualifier 466-EZ
427-DR	Prescriber Last Name		R	
498-PM	Prescriber Phone Number		O	
468-2E	Primary Care Provider ID Qualifier		O	
421-DL	Primary Care Provider ID		O	
470-4E	Primary Care Provider Last Name		O	
364-2J	Prescriber First Name		O	
365-2K	Prescriber Street Address		O	
366-2M	Prescriber City Address		O	
368-2P	Prescriber Zip/Postal Zone		O	

Coordination of Benefits Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc claims
Scenario 1 - Other Payer Amount Paid Repetitions Only	X	OCC 2, 3 & 4
Scenario 2- Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
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
111-AM	Segment Identification	05	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count		M	Up to 3 occurrences
338-5C	Other Payer Coverage Type		M	01= Primary 02= Secondary 03= Tertiary
339-6C	Other Payer ID Qualifier		R	03= BIN
340-7C	Other Payer ID		R	
443-E8	Other Payer Date		R	CCYYMMDD
341-HB	Other Payer Amount Paid Count		RW	Required when Other Payer Amount Paid Qualifier (342-HC) is used
342-HC	Other Payer Amount Paid Qualifier		RW	Required when Other Payer Amount Paid (431- DV) is used Not used when Other Payer Reject Count (471-5E) is submitted. 07= Drug Benefit 08= Sum of all Reimbursement 99= Other
431-DV	Other Payer Amount Paid		RW	Required when another payer has approved payment for some/all of the billing Not used for OCC 8 when Other Payer- Patient Responsibility Amount (352-NQ) is submitted.
471-5E	Other Payer Reject Count		RW	Required when Other Payer Reject Code (472- 6E) is used Not used when Other Payer Amount Paid Qualifier (342-HC) is

				submitted.
472-6E	Other Payer Reject Code		RW	Required when another payer has denied the payment for the billing, designated with Coverage Code (308-C8) = 3

Coordination of Benefits Segment Questions	Check	Claim Billing/Claim Rebill
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc claims
Scenario 1 - Other Payer Amount Paid Repetitions Only	X	OCC 2, 3 & 4
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
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
111-AM	Segment Identification	05	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count		M	Up to 3 occurrences
338-SC	Other Payer Coverage Type		M	01= Primary 02= Secondary 03= Tertiary
339-6C	Other Payer ID Qualifier		R	03= BIN
346-7C	Other Payer ID		R	
443-E8	Other Payer Date		R	CCYYMMOD
353-NR	Other Payer-Patient Responsibility Amount Count		RW	Required when Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.
351-NP	Other Payer-Patient Responsibility Amount Qualifier		RW	Required if Other Payer-Patient Amount (352-NQ) is used.
352-NQ	Other Payer-Patient Responsibility Amount		RW	Required if necessary for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted.

Compound Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent		
This Segment is situational	X	Only required for submission of Compound claims (field 406-D6 = 2)

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	10	M	Compound Segment
450-EF	Compound Dosage Form Description		M	Requires two (2) characters ranging from 01-18 or six (6) characters beginning with "c" followed by five (5) digits
451-EG	Compound Dispensing Unit Form Indicator	1, 2, 3	M	
447-EC	Compound Ingredient Component Count		M	This count must match the submitted number of repetitions.
488-RE	Compound Product ID Qualifier	03	M	03= NDC
489-TE	Compound Product ID		M	Component NDC(s) of compound mixture
448-ED	Compound Ingredient Quantity		M	Amount expressed in metric decimal units
449-EE	Compound Ingredient Cost		R	
490-UE	Compound Ingredient Basis of Cost Determination		R	
362-2G	Compound Ingredient Modifier Code Count		R	
363-2H	Compound Ingredient Modifier Code		R	

Workers' Compensation Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent		
This Segment is situational	X	

Field #	Workers' Compensation Segment Segment Identification (111-AM) = "Ø6"	Value	Payer Usage	Claim Billing/Claim Rebill
434-DY	Date Of Injury		R	
315-CF	Employer Name		O	
316-CG	Employer Street Address		O	
317-CH	Employer City Address		O	
318-CI	Employer State/Province Address		O	
319-CJ	Employer Zip/Postal Zone		O	
32Ø-CK	Employer Phone Number		O	
321-CL	Employer Contact Name		O	
327-CR	Carrier Id		O	
435-DV	Claim/Reference ID		O	
117-TR	Billing Entity Type Indicator		O	
118-TS	Pay To Qualifier		O	
119-TT	Pay To ID		O	
120-TU	Pay To Name		O	
121-TV	Pay To Street Name		O	
122-TW	Pay To City Address		O	
123-TX	Pay To State/Provence Address		O	
124-TY	Pay To Zip/Postal Zone		O	
125-TZ	Generic Equivalent Product ID Qualifier		O	
126-UA	Generic Equivalent Product ID		O	

Clinical Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent		
This Segment is situational	X	

Field #	Workers' Compensation Segment Segment Identification (111-AM) = "13"	Value	Payer Usage	Claim Billing/Claim Rebill
491-VE	Diagnosis Code Count		R	
492-WE	Diagnosis Code Qualifier		RW	Required if Diagnosis Code (424-DO) is used.
424-DO	Diagnosis Code		RW	

Processing Notes

Provider must follow all applicable regulations and processes established by the FDA, CDC, and the Health Department, among others; details will be part of future pharmacy audits.

General Processing

1. Claim submissions must contain one (1) occurrence of claim data.

Billing Compounds

1. In the CLAIM segment enter a "0" as NDC (automatic in most pharmacy point of sale systems)

DUR

Claims may reject with Reject Code 88 for DUR edits such as Drug-Drug Interaction, Ingredient Duplication, Therapeutic Duplication, Drug Age Precaution, Drug-Allergy Interaction, and High or Low Dose Alerts. These soft edits can be overridden with the entry of the appropriate following NCPDP service codes:

- Reason for Service Code (Conflict)
- Professional Service Code (Intervention)
- Result of Service Code (Outcome)

Pharmacies must use the appropriate override code for the action taken, and action must be documented for auditing purposes.

Part III: Claim Billing / Claim ReBill Accepted/Paid (or Duplicate of Paid) Response

Transaction Header	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN Number	<Plan Name>: Bin Number	M	See <Plan Name> Section
102-A2	Version/Release Number	D0	M	Version D.0
103-A3	Transaction Code	B1	M	
109-A9	Transaction Count	1	M	Max Number 1 transaction per transmission
501-F1	Header Response Status	A = Accepted		
202-B2	Service Provider ID Qualifier		M	01 = NPI 07= NCPDP NABP
201-B1	Service Provider ID		M	
401-D1	Date of Service		M	CCYYMMDD

Message Segment	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging. (additional message text)

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	20	M	Message Segment
5Ø4-F4	Message		RW	Imp Guide: Required if text is needed for clarification or detail.

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

111-AM	Segment Identification	25	M	Response Insurance Segment
3Ø1-C1	Group ID		M	Imp Guide: Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available. Required to identify the actual group that was used when multiple group coverages exist. Payer Requirement: Required
545-2F	Network Reimbursement ID		M	Imp Guide: Required if needed to identify the network for the covered member. Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available. Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist. Payer Requirement: Required
3Ø2-C2	Cardholder ID		M	Imp Guide: Required if the identification to be used in future transactions is different than what was submitted on the request. Payer Requirement: Required

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

Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
111-AM	Segment Identification	29	M	
31Ø-CA	Patient First Name		M	Imp Guide: Required if known.
311-CB	Patient Last Name			Imp Guide: Required if known.
3Ø4-C4	Date Of Birth	CCYYMMDD		Imp Guide: Required if known.

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	21	M	
112-AN	Transaction Response Status	P = Paid D = Duplicate Paid	M	
5Ø3-F3	Authorization Number		RW	Imp Guide: Required if needed to identify the transaction.
547-5F	Approved Message Code Count		RW	Imp Guide: Required if Approved Message Code (548-6F) is used.
548-6F	Approved Message Code		RW	Imp Guide: Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity.
13Ø-UF	Additional Message Information Count		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 curren
549-7F	Help Desk Phone Number Qualifier		RW	Imp Guide: Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	Help Desk Phone Number		RW	Imp Guide: Required if needed to provide a support telephone number to the receiver. (888) 333-2757

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	22	M	

455-EM	Prescription/Service Reference Number Qualifier	1 = RxBilling	M	Imp Guide: 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	
551-9F	Preferred Product Count	Maximum count of 6.	RW	Imp Guide: Required if Preferred Product ID (553-AR) is used.
552-AP	Preferred Product Id Qualifier		RW	Imp Guide: Required if Preferred Product ID (553-AR) is used.
553-AR	Preferred Product Id		RW	Imp Guide: Required if a product preference exists that needs to be communicated to the receiver via an ID
554-AS	Preferred Product Incentive		RW	Imp Guide: Required if there is a known incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU).
555-AT	Preferred Product Cost Share Incentive		RW	Imp Guide: Required if there is a known patient financial responsibility incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU).
556-AU	Preferred Product Description		RW	Imp Guide: Required if a product preference exists that either cannot be communicated by the Preferred Product ID (553-AR) or to clarify the Preferred Product ID (553-AR)

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

Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
111-AM	Segment Identification	23	M	
5Ø5-F5	Patient Pay Amount		M	Payer Requirement: Required
5Ø6-F6	Ingredient Cost Paid		M	Payer Requirement: Required
5Ø7-F7	Dispensing Fee Paid		M	
557-AV	Tax Exempt Indicator		RW	
558-AW	Flat Sales Tax Amount Paid		RW	
559-AX	Percentage Sales Tax Amount Paid		RW	Imp Guide: Required if this value is used to arrive at the final reimbursement. Required if Percentage Sales Tax Amount Submitted (482-GE) is greater than zero (Ø). Required if Percentage Sales Tax Rate

				Paid (56Ø-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used
56Ø-AY	Percentage Sales Tax Rate Paid		RW	Imp Guide: Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).
561-AZ	Percentage Sales Tax Basis Paid		RW	Imp Guide: Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).
521-FL	Incentive Amount Paid		RW	
563-J2	Other Amount Paid Count	Maximum count of 3.-	RW	Imp Guide: Required if Other Amount Paid (565-J4) is used.
564-J3	Other Amount Paid Qualifier	01-Delivery Cost 02-Shipping Cost 03- Postage Cost 04- Administrative Cost 09- Compound preparation Cost Submitted	RW	
565-J4	Other Amount Paid		RW	
566-J5	Other Payer Amount Recognized			Imp Guide: Required if this value is used to arrive at the final reimbursement. Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported. Payer Requirement
5Ø9-F9	Total Amount Paid		M	
522-FM	Basis Of Reimbursement Determination		M	Imp Guide: Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing. Payer Requirement
523-FN	Amount Attributed To Sales Tax		RW	Imp Guide: Required if Patient Pay Amount (5Ø5-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.
512-FC	Accumulated Deductible Amount		RW	Imp Guide: Provided for informational purposes only
513-FD	Remaining Deductible Amount		RW	Imp Guide: Provided for informational purposes only
514-FE	Remaining Benefit Amount		RW	Imp Guide: Provided for informational purposes only
517-FH	Amount Applied To Periodic Deductible		RW	Imp Guide: Required if Patient Pay Amount (5Ø5-F5) includes deductible
518-FI	Amount Of Copay		RW	Imp Guide: Required if Patient Pay Amount (5Ø5-F5 includes copay as patient financial responsibility.
520-FK	Amount Exceeding Periodic Benefit Maximum		RW	Imp Guide: Required if Patient Pay Amount (5Ø5-F5 includes amount exceeding periodic benefit maximum
571-NZ	Amount Attributed To Processor Fee		RW	Imp Guide: Required if the customer is responsible for 1ØØ% of the prescription payment and when the provider net sale is less than the amount the customer is

				expected to pay.
575-EQ	Patient Sales Tax Amount		RW	Imp Guide: Used when necessary to identify the Patient's portion of the Sales Tax. *Note: When we reviewed claims for members that paid the sales tax amount, this field is not going back.
574-2Y	Plan Sales Tax Amount		RW	Imp Guide: Used when necessary to identify the Plan's portion of the Sales Tax
572-4U	Amount Of Coinsurance		RW	Imp Guide: Required if Patient Pay Amount (5Ø5-F5) includes coinsurance as patient financial responsibility.
573-4V	Basis Of Calculation Coinsurance		RW	Imp Guide: Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill).
392-MU	Benefit Stage Count	Maximum count of 4.	RW	Imp Guide: Required if Benefit Stage Amount (394-MW) is used
393-MV	Benefit Stage Qualifier		RW	Imp Guide: Required if Benefit Stage Amount (394-MW) is used
394-MW	Benefit Stage Amount		RW	Imp Guide: 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. Required if necessary for state/federal/regulatory agency programs
577-G3	Estimated Generic Savings		RW	Imp Guide: This information should be provided when a patient selected the brand drug and a generic form of the drug was available. It will contain an estimate of the difference between the cost of the brand drug and the generic drug, when the brand drug is more expensive than the generic.
128-UC	Spending Account Amount Remaining		RW	Imp Guide: 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.
129-UD	Health Plan-Funded Assistance Amount		RW	Imp Guide: Required when the patient meets the plan-funded assistance criteria, to reduce Patient Pay Amount (5Ø5-F5). The resulting Patient Pay Amount (5Ø5-F5) must be greater than or equal to zero.
133-UJ	Amount Attributed To Provider Network Selection		RW	Imp Guide: Required if Patient Pay Amount (5Ø5-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	Imp Guide: Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand drug
135-UM	Amount Attributed To Product Selection/Non Preferred		RW	Imp Guide: Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a

	Formulary Selection			non-preferred formulary product.
136-UN	Amount Attributed To Product Selection/Brand Non-Preferred Formulary Selection		RW	Imp Guide: Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand non-preferred formulary product.
137-UP	Amount Attributed To Coverage Gap		RW	Imp Guide: Required when the patient's financial responsibility is due to the coverage gap.
148-U8	Ingredient Cost Contracted/Reimbursable Amount		RW	Imp Guide: Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency.
149-U9	Dispensing Fee Contracted/Reimbursable Amount		RW	Imp Guide: Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency

Response DUR/PPS Segment	**Check**	**Claim Billing/Claim Rebill** If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	x	

Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
111-AM	Segment Identification	24	RW	
567-J6	Dur/Pps Response Code Counter		RW	
439-E4	Reason For Service Code		RW	
528-FS	Clinical Significance Code		RW	
529-FT	Other Pharmacy Indicator		RW	
53Ø-FU	Previous Date Of Fill		RW	
531-FV	Quantity Of Previous Fill		RW	
532-FW	Database Indicator		RW	
533-FX	Other Prescriber Indicator		RW	
544-FY	Dur Free Text Message		RW	
57Ø-NS	Dur Additional Text		RW	

Response Coordination Of Benefits Segment	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	24	M	
355-NT	Other Payer Id Count	Maximum count of 3.		
338-5C	Other Payer Coverage Type			
339-6C	Other Payer Id Qualifier			
34Ø-7C	Other Payer Id			
991-MH	Other Payer Processor Control Number			
356-NU	Other Payer Cardholder Id			Imp Guide: Required if Other Payer ID (34Ø-7C) is used.
992-MJ	Other Payer Group Id			Imp Guide: Required if other insurance information is available for coordination of benefits.
142-UV	Other Payer Person Code			
127-UB	Other Payer Help Desk Phone Number			
143-UW	Other Payer Patient Relationship Code			
144-UX	Other Payer Benefit Effective Date			
145-UY	Other Payer Benefit Termination Date			

Part IV: Claim Billing / Claim ReBill Accepted/Rejected Response

Transaction Header	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN Number	<Plan Name>: Bin Number	M	See <Plan Name> Section

102-A2	Version/Release Number	D0	M	Version D.0
103-A3	Transaction Code	B1	M	
109-A9	Transaction Count	1	M	Max Number 1 transaction per transmission
501-F1	Header Response Status	A = Accepted		
202-B2	Service Provider ID Qualifier		M	01 = NPI 07= NCPDP NABP
201-B1	Service Provider ID		M	
401-D1	Date of Service		M	CCYYMMDD

Message Segment	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging. (Additional message text)

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	20	M	Message Segment
5Ø4-F4	Message		RW	Imp Guide: Required if text is needed for clarification or detail.

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	25	M	Response Insurance Segment
3Ø1-C1	Group ID		M	Imp Guide: Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available. Required to identify the actual group that was used when multiple group coverages exist. Payer Requirement: Required
545-2F	Network Reimbursement ID		M	Imp Guide: Required if needed to identify the network for the

				covered member. Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available. Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist. Payer Requirement: Required
3Ø2-C2	Cardholder ID		M	Imp Guide: Required if the identification to be used in future transactions is different than what was submitted on the request. Payer Requirement: Required

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	29	M	
31Ø-CA	Patient First Name		M	Imp Guide: Required if known.
311-CB	Patient Last Name			Imp Guide: Required if known.
3Ø4-C4	Date Of Birth	CCYYMMDD		Imp Guide: Required if known.

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

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	21	M	
112-AN	Transaction Response Status	P = Paid D = Duplicate Paid	M	
5Ø3-F3	Authorization Number		RW	Imp Guide: Required if needed to identify the transaction.

547-5F	Approved Message Code Count		RW	Imp Guide: Required if Approved Message Code (548-6F) is used.
548-6F	Approved Message Code		RW	Imp Guide: Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity.
13Ø-UF	Additional Message Information Count		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		RW	Imp Guide: Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	Help Desk Phone Number		RW	Imp Guide: Required if needed to provide a support telephone number to the receiver. 1-(866) 840-1877

Response Claim Segment	**Check**	**Claim Billing/Claim Rebill** If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
111-AM	Segment Identification	22	M	
455-EM	Prescription/Service Reference Number Qualifier	1 = RxBilling	M	Imp Guide: 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	
551-9F	Preferred Product Count	Maximum count of 6.	RW	Imp Guide: Required if Preferred Product ID (553-AR) is used.
552-AP	Preferred Product Id Qualifier		RW	Imp Guide: Required if Preferred Product ID (553-AR) is used.
553-AR	Preferred Product Id		RW	Imp Guide: Required if a product preference exists that needs to be communicated to the receiver via an ID

554-AS	Preferred Product Incentive		RW	Imp Guide: Required if there is a known incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU).
555-AT	Preferred Product Cost Share Incentive		RW	Imp Guide: Required if there is a known patient financial responsibility incentive amount associated with the Preferred Product ID (553-AR) and/or Preferred Product Description (556-AU).
556-AU	Preferred Product Description		RW	Imp Guide: Required if a product preference exists that either cannot be communicated by the Preferred Product ID (553-AR) or to clarify the Preferred Product ID (553-AR)

Response DUR/PPS Segment	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	x	

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	24	RW	
567-J6	Dur/Pps Response Code Counter		RW	
439-E4	Reason For Service Code		RW	
528-FS	Clinical Significance Code		RW	
529-FT	Other Pharmacy Indicator		RW	
53Ø-FU	Previous Date Of Fill		RW	
531-FV	Quantity Of Previous Fill		RW	
532-FW	Database Indicator		RW	
533-FX	Other Prescriber Indicator		RW	
544-FY	Dur Free Text Message		RW	
57Ø-NS	Dur Additional Text		RW	

Response Coordination Of Benefits Segment	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	24	M	
355-NT	Other Payer Id Count	Maximum count of 3.		
338-5C	Other Payer Coverage Type			
339-6C	Other Payer Id Qualifier			
34Ø-7C	Other Payer Id			
991-MH	Other Payer Processor Control Number			
356-NU	Other Payer Cardholder Id			Imp Guide: Required if Other Payer ID (34Ø-7C) is used.
992-MJ	Other Payer Group Id			Imp Guide: Required if other insurance information is available for coordination of benefits.
142-UV	Other Payer Person Code			
127-UB	Other Payer Help Desk Phone Number			
143-UW	Other Payer Patient Relationship Code			
144-UX	Other Payer Benefit Effective Date			
145-UY	Other Payer Benefit Termination Date			

Part V: Reversal Transaction Segments

The following table lists the segments available in a Billing Transaction. The table also lists values as defined under NCPDP Version **D.0** for your reference.

Fields that are not used in the Claim Reversal Transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the payer sheet.

Maximum Number of Transactions Supported per Transmission	1
What is the Reversal Window? (If transaction is billed today, what is the timeframe for reversals to be allowed?)	Standard is 90 days but can be plan specific.

Transaction Header	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN Number	**<Plan Name>:** Bin Number	M	**See <Plan Name> Section**
102-A2	Version/Release Number	D0	M	Version D.0
103-A3	Transaction Code	B2	M	
104-A4	Processor Control Number	**<Plan Name>**: PCN	M	**See <Plan Name> Section**
109-A9	Transaction Count	1	M	Max Number 1 transaction per transmission
202-B2	Service Provider ID Qualifier		M	01 = NPI 07= NCPDP NABP
201-B1	Service Provider ID		M	
401-D1	Date of Service		M	CCYYMMDD
110-AK	Software Vender/Certification ID		M	Send spaces

Insurance Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	04	M	Insurance Segment
302-C2	Cardholder ID		M	
303-C3	Person Code		R	

Claim Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	
This payer supports partial fills		
This payer does not support partial fills	X	

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	07	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	01	M	1= Rx Billing Code
402-D2	Prescription/Service Reference Number		M	
436-El	Product/Service ID Qualifier	03	M	03= NDC
407-D7	Product/Service ID		R	NDC
403-D3	Fill Number		R	0 = Original Dispensing 1-99= Refill Number
308-C8	Other Coverage Code		RW	Required when communicating summation of other coverage information collected from other payers. See Customer Coverage below. 00 or 01= Not a COB claim 02= Other Coverage exists, and payment has been collected 03= Other Coverage Billed-claim not covered 04=Other Coverage exists, and no payment has been collected

Pricing Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	

	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	11	M	Pricing Segment
430-DU	Gross Amount Due		R	
438-E3	Incentive Amount Submitted		RW	Required when value has effect on Gross Amount Due (430-DU) calculation

Coordination of Benefits Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	Segment Identification	05	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count		M	Up to 3 occurrences
338-5C	Other Payer Coverage Type		M	01= Primary 02= Secondary 03= Tertiary

Part VI: Revisions

Date of changes	Changes	Revisions
2022/09/20	Added Additional NCPCP Guidelines for: +Added Part III – Claim Billing/ Claim Rebill Accepted/ Paid or Duplicate Response +Added Part IV - Claim Billing/ Claim Rebill Accepted/ Rejected Response	Rev.202209
2021/11/17	Bin Number changed	Rev.202112
2021/09/01	+ Added more documentation to field situations and descriptions + Added some style to the document + Added Revision Number +Added History track change	Rev. 2021010
2020/09/25	Document Creation	Rev. 20200925