NCPDP VERSION D CLAIM BILLING/CLAIM REBILL

REQUEST CLAIM BILLING/CLAIM REBILL PAYER SHEET

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

GENERAL INFORMATION

Payer Name: AscellaHealth  
Plan Name/Group Name: Healthy Transportation Foundation (HTF)  
BIN: 600428  
PCN: AH  
Processor: SS&C Health  
Effective as of: 05/20/2021  
NCPDP Data Dictionary Version Date: July, 2007  
NCPDP Telecommunication Standard Version/Release #: D.0  
NCPDP External Code List Version Date: March, 2010  
Contact/Information Source: SS&C Health Help Desk at 1-866-921-7286  
Certification Testing Window: Certification Not Required.  
Certification Contact Information: Certification Not Required.  
Provider Relations Help Desk Info: SS&C Health Help Desk at 1-866-921-7286  
Other versions supported:  

OTHER TRANSCTIONS SUPPORTED

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

<table>
<thead>
<tr>
<th>Transaction Code</th>
<th>Transaction Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>B2</td>
<td>Reversal</td>
</tr>
</tbody>
</table>

FIELD LEGEND FOR COLUMNS

<table>
<thead>
<tr>
<th>Payer Usage Column</th>
<th>Value</th>
<th>Explanation</th>
<th>Payer Situation Column</th>
</tr>
</thead>
<tbody>
<tr>
<td>MANDATORY</td>
<td>M</td>
<td>The Field is mandatory for the Segment in the designated Transaction.</td>
<td>No</td>
</tr>
<tr>
<td>REQUIRED</td>
<td>R</td>
<td>The Field has been designated with the situation of &quot;Required&quot; for the Segment in the designated Transaction.</td>
<td>No</td>
</tr>
<tr>
<td>QUALIFIED REQUIREMENT</td>
<td>RW</td>
<td>&quot;Required when&quot;. The situations designated have qualifications for usage (&quot;Required if x&quot;, &quot;Not required if y&quot;).</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

CLAIM BILLING/CLAIM REBILL TRANSACTION

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

<table>
<thead>
<tr>
<th>Transaction Header Segment Questions</th>
<th>Check</th>
<th>Claim Billing/Claim Rebill</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Segment is always sent</td>
<td>X</td>
<td>If Situational, Payer Situation</td>
</tr>
</tbody>
</table>
| Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer issued | Certification Not Required.  
| Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN issued |  
| Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used |  

<table>
<thead>
<tr>
<th>Transaction Header Segment</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>101-A1 BIN NUMBER</td>
<td>600428</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>102-A2 VERSION/RELEASE NUMBER</td>
<td>D0</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>103-A3 TRANSACTION CODE</td>
<td>B1, B3</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>104-A4 PROCESSOR CONTROL NUMBER</td>
<td>AH</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>109-A9 TRANSACTION COUNT</td>
<td>1 - 4</td>
<td>M</td>
<td>1 – 4 transactions for transmissions</td>
<td></td>
</tr>
</tbody>
</table>
### Transaction Header Segment

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>202-B2</td>
<td>SERVICE PROVIDER ID QUALIFIER</td>
<td>Ø1</td>
<td>M</td>
<td>Only value 'Ø1' (NPI) accepted.</td>
</tr>
<tr>
<td>201-B1</td>
<td>SERVICE PROVIDER ID</td>
<td></td>
<td>M</td>
<td>NPI of pharmacy</td>
</tr>
<tr>
<td>401-D1</td>
<td>DATE OF SERVICE</td>
<td></td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>110-AK</td>
<td>SOFTWARE VENDOR/CERTIFICATION ID</td>
<td>6Ø1DN3ØY</td>
<td>M</td>
<td>6Ø1DN3ØY</td>
</tr>
</tbody>
</table>

### Insurance Segment Questions

This Segment is always sent: **X**

### Insurance Segment

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>302-C2</td>
<td>CARDHOLDER ID</td>
<td></td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>312-CC</td>
<td>CARDHOLDER FIRST NAME</td>
<td></td>
<td>R</td>
<td>Imp Guide: Required if necessary for state/federal/regulatory agency programs when the cardholder has a first name.</td>
</tr>
<tr>
<td>313-CD</td>
<td>CARDHOLDER LAST NAME</td>
<td></td>
<td>R</td>
<td>Imp Guide: Required if necessary for state/federal/regulatory agency programs.</td>
</tr>
<tr>
<td>301-C1</td>
<td>GROUP ID</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if necessary for state/federal/regulatory agency programs. Required if needed for pharmacy claim processing and payment. Payer Requirement: As printed on the card</td>
</tr>
</tbody>
</table>

### Patient Segment Questions

This Segment is always sent: **X**

This Segment is situational: **C**

### Patient Segment

<table>
<thead>
<tr>
<th>Field</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>304-C4</td>
<td>DATE OF BIRTH</td>
<td></td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>305-C5</td>
<td>PATIENT GENDER CODE</td>
<td></td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>310-CA</td>
<td>PATIENT FIRST NAME</td>
<td></td>
<td>R</td>
<td>Imp Guide: Required when the patient has a first name.</td>
</tr>
<tr>
<td>311-CB</td>
<td>PATIENT LAST NAME</td>
<td></td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Claim Segment Questions</td>
<td>Check</td>
<td>Claim Billing/Claim Rebill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This Segment is always sent</td>
<td>X</td>
<td>If Situational, Payer Situation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This payer supports partial fills</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This payer does not support partial fills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>455-EM</td>
<td>PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER</td>
<td>Ø1 = Rx Billing</td>
<td>M</td>
<td>Imp Guide: For Transaction Code of “B1”, in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing).</td>
</tr>
<tr>
<td>402-D2</td>
<td>PRESCRIPTION/SERVICE REFERENCE NUMBER</td>
<td></td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>436-E1</td>
<td>PRODUCT/SERVICE ID QUALIFIER</td>
<td>øø – Not Specified ø3-National Drug Code (NDC)</td>
<td>M</td>
<td>øø = Multi-Ingredient Compound billing</td>
</tr>
<tr>
<td>407-D7</td>
<td>PRODUCT/SERVICE ID</td>
<td>ø = If Compound, otherwise 11 digit NDC</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>456-EN</td>
<td>ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER</td>
<td>RW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>457-EP</td>
<td>ASSOCIATED PRESCRIPTION/SERVICE DATE</td>
<td>RW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>422-E7</td>
<td>QUANTITY DISPENSED</td>
<td>R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>403-D3</td>
<td>FILL NUMBER</td>
<td>R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>405-D5</td>
<td>DAYS SUPPLY</td>
<td>R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>406-D6</td>
<td>COMPOUND CODE</td>
<td>R=Not a Compound;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>408-D8</td>
<td>DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE</td>
<td>R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>414-DE</td>
<td>DATE PRESCRIPTION WRITTEN</td>
<td>R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>415-DF</td>
<td>NUMBER OF REFILLS AUTHORIZED</td>
<td>R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>419-DJ</td>
<td>PRESCRIPTION ORIGIN CODE</td>
<td>Imp Guide: Required if necessary for plan benefit administration.</td>
<td></td>
<td>Payer Requirement: Required on original Rx. Optional on refill Rx.</td>
</tr>
<tr>
<td>308-C8</td>
<td>OTHER COVERAGE CODE</td>
<td>Value:</td>
<td>RW</td>
<td>Imp Guide: Required if needed by receiver, to</td>
</tr>
<tr>
<td>Field #</td>
<td>NCPDP Field Name</td>
<td>Value</td>
<td>Payer Usage</td>
<td>Payer Situation</td>
</tr>
<tr>
<td>---------</td>
<td>------------------</td>
<td>-------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>00 = Not Specified</td>
<td>00 = Not Specified</td>
<td>01 = No Other Coverage</td>
<td>Communication a summation of other coverage information that has been collected from other payers. Required for Coordination of Benefits. <strong>Payer Requirement:</strong> Same as Imp Guide.</td>
<td></td>
</tr>
<tr>
<td>343-HD</td>
<td>DISPENSING STATUS</td>
<td>RW</td>
<td><strong>Imp Guide:</strong> Required for the partial fill or the completion fill of a prescription. <strong>Payer Requirement:</strong> (Same as Imp Guide).</td>
<td></td>
</tr>
<tr>
<td>344-HF</td>
<td>QUANTITY INTENDED TO BE DISPENSED</td>
<td>RW</td>
<td><strong>Imp Guide:</strong> Required for the partial fill or the completion fill of a prescription. <strong>Payer Requirement:</strong> (Same as Imp Guide).</td>
<td></td>
</tr>
<tr>
<td>345-HG</td>
<td>DAYS SUPPLY INTENDED TO BE DISPENSED</td>
<td>RW</td>
<td><strong>Imp Guide:</strong> Required for the partial fill or the completion fill of a prescription. <strong>Payer Requirement:</strong> (Same as Imp Guide).</td>
<td></td>
</tr>
</tbody>
</table>

### Pricing Segment Questions

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>409-D9</td>
<td>INGREDIENT COST SUBMITTED</td>
<td>R</td>
<td><strong>Imp Guide:</strong> Required if its value has an effect on the Gross Amount Due (430-DU) calculation. <strong>Payer Requirement:</strong> Same as Imp Guide.</td>
<td></td>
</tr>
<tr>
<td>412-DC</td>
<td>DISPENSING FEE SUBMITTED</td>
<td>RW</td>
<td><strong>Imp Guide:</strong> Required if its value has an effect on the Gross Amount Due (430-DU) calculation. <strong>Payer Requirement:</strong> Same as Imp Guide.</td>
<td></td>
</tr>
<tr>
<td>433-DX</td>
<td>PATIENT PAID AMOUNT SUBMITTED</td>
<td>RW</td>
<td><strong>Imp Guide:</strong> Required if this field could result in different coverage, pricing, or patient financial responsibility. <strong>Payer Requirement:</strong> Same as Imp Guide.</td>
<td></td>
</tr>
<tr>
<td>438-E3</td>
<td>INCENTIVE AMOUNT SUBMITTED</td>
<td>RW</td>
<td><strong>Imp Guide:</strong> Required if its value has an effect on the Gross Amount Due (430-DU) calculation. <strong>Payer requirement:</strong> Same as Imp Guide. Vaccine Administration: Pharmacy must submit value greater than $0.00 to request reimbursement for vaccine administration.</td>
<td></td>
</tr>
<tr>
<td>481-HA</td>
<td>FLAT SALES TAX AMOUNT SUBMITTED</td>
<td>RW</td>
<td><strong>Imp Guide:</strong> Required if its value has an effect on the Gross Amount Due (430-DU) calculation. <strong>Payer Requirement:</strong> Same as Imp Guide.</td>
<td></td>
</tr>
<tr>
<td>482-GE</td>
<td>PERCENTAGE SALES TAX AMOUNT SUBMITTED</td>
<td>RW</td>
<td><strong>Imp Guide:</strong> Required if its value has an effect on the Gross Amount Due (430-DU) calculation.</td>
<td></td>
</tr>
<tr>
<td>Field #</td>
<td>NCPDP Field Name</td>
<td>Value</td>
<td>Payer Usage</td>
<td>Payer Situation</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------</td>
<td>-------</td>
<td>-------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>483-HE</td>
<td>PERCENTAGE SALES TAX RATE SUBMITTED</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX) <strong>Payer Requirement:</strong> Same as Imp Guide</td>
</tr>
<tr>
<td>484-JE</td>
<td>PERCENTAGE SALES TAX BASIS SUBMITTED</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX) <strong>Payer Requirement:</strong> Same as Imp Guide</td>
</tr>
<tr>
<td>426-DQ</td>
<td>USUAL AND CUSTOMARY CHARGE</td>
<td>R</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if needed per trading partner agreement. <strong>Payer Requirement:</strong> Same as Imp Guide. Vaccine Administration: Pharmacy must submit</td>
</tr>
<tr>
<td>43Ø-DU</td>
<td>GROSS AMOUNT DUE</td>
<td>R</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DUR/PPS Segment Questions**

<table>
<thead>
<tr>
<th>Check</th>
<th>Claim Billing/Claim Rebill</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This Segment is always sent</td>
</tr>
<tr>
<td></td>
<td>This Segment is situational X To be sent if additional information is needed to be sent.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>473-7E</td>
<td>DUR/PPS CODE COUNTER</td>
<td>Maximum of 9 occurrences. RW</td>
<td><strong>Imp Guide:</strong> Required if DUR/PPS Segment is used. <strong>Payer Requirement:</strong> Same as Imp Guide.</td>
<td></td>
</tr>
<tr>
<td>439-E4</td>
<td>REASON FOR SERVICE CODE</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. <strong>Payer Requirement:</strong> Same as Imp Guide. Vaccine Administration: Pharmacy must submit</td>
</tr>
<tr>
<td>Field #</td>
<td>NCPDP Field Name</td>
<td>Value</td>
<td>Payer Usage</td>
<td>Payer Situation</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------</td>
<td>-------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>440-E5</td>
<td>PROFESSIONAL SERVICE CODE</td>
<td></td>
<td>RW</td>
<td>a value of PH – Preventative Health Care indicating that the pharmacist is certified to provide the service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Imp Guide: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Payer Requirement:</strong> Same as Imp Guide. Vaccine Administration: Pharmacy must submit a value of MA – Medication Administration to indicate an action of supplying a vaccine.</td>
</tr>
<tr>
<td>441-E6</td>
<td>RESULT OF SERVICE CODE</td>
<td></td>
<td>RW</td>
<td><strong>Imp Guide:</strong> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Payer Requirement:</strong> Same as Imp Guide. Vaccine Administration: Pharmacy must submit a value of 3N – Medication Administered to reflect cognitive service.</td>
</tr>
</tbody>
</table>

** End of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet **
**RESPONSE CLAIM BILLING/CLAIM REBILL PAYER SHEET**

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

**GENERAL INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>106-A2 VERSION/RELEASE NUMBER</td>
<td>DØ</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>103-A3 TRANSACTION CODE</td>
<td>B1, B3</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>109-A9 TRANSACTION COUNT</td>
<td>Same value as in request</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>501-F1 HEADER RESPONSE STATUS</td>
<td>A = Accepted</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>202-B2 SERVICE PROVIDER ID QUALIFIER</td>
<td>Same value as in request</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>201-B1 SERVICE PROVIDER ID</td>
<td>Same value as in request</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>401-D1 DATE OF SERVICE</td>
<td>Same value as in request</td>
<td>M</td>
<td></td>
</tr>
</tbody>
</table>

**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**

If Situational, Payer Situation

**Response Patient Segment Segments**

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>310-CA PATIENT FIRST NAME</td>
<td>RW</td>
<td>Payer Requirement: Same as Imp Guide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>311-CB PATIENT LAST NAME</td>
<td>RW</td>
<td>Payer Requirement: Same as Imp Guide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>304-C4 DATE OF BIRTH</td>
<td>RW</td>
<td>Payer Requirement: Same as Imp Guide</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**

If Situational, Payer Situation
<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>112-AN</td>
<td>TRANSACTION RESPONSE STATUS</td>
<td>P=Paid D=Duplicate of Paid</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>547-5F</td>
<td>APPROVED MESSAGE CODE COUNT</td>
<td>Maximum count of 5</td>
<td>RW</td>
<td>Imp Guide: Required if Approved Message Code (548-6F) is used. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>548-6F</td>
<td>APPROVED MESSAGE CODE</td>
<td></td>
<td>RW</td>
<td>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. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if Additional Message Information (526-FQ) is used. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required when additional text is needed for clarification or detail. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td></td>
<td>RW</td>
<td>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. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>549-7F</td>
<td>HELP DESK PHONE NUMBER QUALIFIER</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if Help Desk Phone Number (550-8F) is used. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>550-8F</td>
<td>HELP DESK PHONE NUMBER</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if needed to provide a support telephone number to the receiver. Payer Requirement: Same as Imp Guide Note: Help Desk Phone Number may continue to be returned in 526-FQ Additional Message Information field.</td>
</tr>
</tbody>
</table>

**Response Claim Segment Questions**

<table>
<thead>
<tr>
<th>Check</th>
<th>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>If Situational, Payer Situation</td>
</tr>
</tbody>
</table>

**Response Claim Segment (111-AM) = “22”**

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>455-EM</td>
<td>PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER</td>
<td>1 = RxBilling</td>
<td>M</td>
<td>Imp Guide: For Transaction Code of “B1”, in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing).</td>
</tr>
<tr>
<td>402-D2</td>
<td>PRESCRIPTION/SERVICE REFERENCE NUMBER</td>
<td></td>
<td>M</td>
<td></td>
</tr>
</tbody>
</table>

Note: Help Desk Phone Number may continue to be returned in 526-FQ Additional Message Information field.
**Response Pricing Segment Questions**

This Segment is always sent

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>505-F5</td>
<td>PATIENT PAY AMOUNT</td>
<td>R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>506-F6</td>
<td>INGREDIENT COST PAID</td>
<td>R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>507-F7</td>
<td>DISPENSING FEE PAID</td>
<td>RW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>558-AW</td>
<td>FLAT SALES TAX AMOUNT PAID</td>
<td>RW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>559-AX</td>
<td>PERCENTAGE SALES TAX AMOUNT PAID</td>
<td>RW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>560-AY</td>
<td>PERCENTAGE SALES TAX RATE PAID</td>
<td>RW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>561-AZ</td>
<td>PERCENTAGE SALES TAX BASIS PAID</td>
<td>RW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>521-FL</td>
<td>INCENTIVE AMOUNT PAID</td>
<td>RW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>563-J2</td>
<td>OTHER AMOUNT PAID COUNT</td>
<td>Maximum count of 3.</td>
<td>RW</td>
<td></td>
</tr>
<tr>
<td>564-J3</td>
<td>OTHER AMOUNT PAID QUALIFIER</td>
<td>RW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>565-J4</td>
<td>OTHER AMOUNT PAID</td>
<td>RW</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Check**

- **Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)**
- **If Situational, Payer Situation**

**Imp Guide:** Required if this value is used to arrive at the final reimbursement.

**Payer Requirement:**
- Same as Imp Guide

- Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (Ø) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement.

- Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).

- Required if Other Amount Claimed Submitted (480-H9) is greater than zero (Ø).
<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>566-J5</td>
<td>OTHER PAYER AMOUNT RECOGNIZED</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> 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. <strong>Payer Requirement:</strong> Same as Imp Guide</td>
</tr>
<tr>
<td>509-F9</td>
<td>TOTAL AMOUNT PAID</td>
<td>RW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>522-FM</td>
<td>BASIS OF REIMBURSEMENT DETERMINATION</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if Ingredient Cost Paid (506-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing. <strong>Payer Requirement:</strong> Same as Imp Guide</td>
</tr>
<tr>
<td>518-FI</td>
<td>AMOUNT OF COPAY</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if Patient Pay Amount (505-F5) includes copay as patient financial responsibility. <strong>Payer Requirement:</strong> Same as Imp Guide</td>
</tr>
<tr>
<td>571-NZ</td>
<td>AMOUNT ATTRIBUTED TO PROCESSOR FEE</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if the customer is responsible for 100% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay. <strong>Payer Requirement:</strong> Same as Imp Guide</td>
</tr>
<tr>
<td>572-4U</td>
<td>AMOUNT OF COINSURANCE</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if Patient Pay Amount (505-F5) includes coinsurance as patient financial responsibility. <strong>Payer Requirement:</strong> Same as Imp Guide</td>
</tr>
<tr>
<td>134-UK</td>
<td>AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient’s selection of a Brand drug. <strong>Payer Requirement:</strong> Same as Imp Guide</td>
</tr>
</tbody>
</table>

**Response DUR/PPS Segment Questions**

- **Check**
  - **Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)**
    - **If Situational, Payer Situation**
  - **This Segment is always sent**
  - **This Segment is situational**
    - **X** Used when needed to relay DUR information to the pharmacy.

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>567-J6</td>
<td>DUR/PPS RESPONSE CODE COUNTER</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if Reason For Service Code (439-E4) is used. <strong>Payer Requirement:</strong> Same as Imp Guide</td>
</tr>
<tr>
<td>439-E4</td>
<td>REASON FOR SERVICE CODE</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if utilization conflict is detected. <strong>Payer Requirement:</strong> Same as Imp Guide</td>
</tr>
<tr>
<td>528-FS</td>
<td>CLINICAL SIGNIFICANCE CODE</td>
<td>RW</td>
<td></td>
<td><strong>Imp Guide:</strong> Required if needed to supply additional information for the utilization conflict. <strong>Payer Requirement:</strong> Same as Imp Guide</td>
</tr>
</tbody>
</table>
### Response DUR/PPS Segment

#### Segment Identification (111-AM) = “24”

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>529-FT</td>
<td>OTHER PHARMACY INDICATOR</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if needed to supply additional information for the utilization conflict. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>530-FU</td>
<td>PREVIOUS DATE OF FILL</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>531-FV</td>
<td>QUANTITY OF PREVIOUS FILL</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (530-FU) is used. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>532-FW</td>
<td>DATABASE INDICATOR</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if needed to supply additional information for the utilization conflict. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>544-FY</td>
<td>DUR FREE TEXT MESSAGE</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if needed to supply additional information for the utilization conflict. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>570-NS</td>
<td>DUR ADDITIONAL TEXT</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if needed to supply additional information for the utilization conflict. Payer Requirement: Same as Imp Guide</td>
</tr>
</tbody>
</table>

### Claim Billing/Claim Rebill Accepted/Rejected Response

#### Claim Billing/Claim Rebill Accepted/Rejected Response

<table>
<thead>
<tr>
<th>Response Transaction Header Segment Questions</th>
<th>Check</th>
<th>Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Segment is always sent</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>102-A2</td>
<td>VERSION/RELEASE NUMBER</td>
<td>DØ</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>103-A3</td>
<td>TRANSACTION CODE</td>
<td>B1, B3</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>109-A9</td>
<td>TRANSACTION COUNT</td>
<td>Same value as in request</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>501-F1</td>
<td>HEADER RESPONSE STATUS</td>
<td>A = Accepted</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>202-B2</td>
<td>SERVICE PROVIDER ID QUALIFIER</td>
<td>Same value as in request</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>201-B1</td>
<td>SERVICE PROVIDER ID</td>
<td>Same value as in request</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>401-D1</td>
<td>DATE OF SERVICE</td>
<td>Same value as in request</td>
<td>M</td>
<td></td>
</tr>
</tbody>
</table>

#### Response Insurance Segment Questions

<table>
<thead>
<tr>
<th>Check</th>
<th>Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Segment is always sent</td>
<td>X Returned if Network Reimbursement ID is applicable.</td>
</tr>
<tr>
<td>This Segment is situational</td>
<td>X</td>
</tr>
<tr>
<td>Field #</td>
<td>NCPDP Field Name</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>545-2F</td>
<td>NETWORK REIMBURSEMENT ID</td>
</tr>
</tbody>
</table>

**Response Patient Segment Questions**

<table>
<thead>
<tr>
<th>Check</th>
<th>Claim Billing/Claim Rebill Accepted/Rejected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If Situational, Payer Situation</td>
</tr>
</tbody>
</table>

This Segment is always sent
This Segment is situational

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Claim Billing/Claim Rebill Accepted/Rejected</th>
</tr>
</thead>
<tbody>
<tr>
<td>310-CA</td>
<td>PATIENT FIRST NAME</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if known. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>311-CB</td>
<td>PATIENT LAST NAME</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if known. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>304-C4</td>
<td>DATE OF BIRTH</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if known. Payer Requirement: Same as Imp Guide</td>
</tr>
</tbody>
</table>

**Response Status Segment Questions**

<table>
<thead>
<tr>
<th>Check</th>
<th>Claim Billing/Claim Rebill Accepted/Rejected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If Situational, Payer Situation</td>
</tr>
</tbody>
</table>

This Segment is always sent

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Claim Billing/Claim Rebill Accepted/Rejected</th>
</tr>
</thead>
<tbody>
<tr>
<td>112-AN</td>
<td>TRANSACTION RESPONSE STATUS</td>
<td>R = Reject</td>
<td>M</td>
<td>Imp Guide: Required if needed to identify the transaction. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>503-F3</td>
<td>AUTHORIZATION NUMBER</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if needed to identify the transaction. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>510-FA</td>
<td>REJECT COUNT</td>
<td>Maximum count of 5.</td>
<td>R</td>
<td>Imp Guide: Required if a repeating field is in error, to identify repeating field occurrence. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>546-4F</td>
<td>REJECT FIELD OCCURRENCE INDICATOR</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if Additional Message Information (526-FQ) is used. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>130-UF</td>
<td>ADDITIONAL MESSAGE INFORMATION COUNT</td>
<td>Maximum count of 25.</td>
<td>RW</td>
<td>Imp Guide: Required if Additional Message Information (526-FQ) is used. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required if Additional Message Information (526-FQ) is used. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td></td>
<td>RW</td>
<td>Imp Guide: Required when additional text is needed for clarification or detail. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>Field #</td>
<td>NCPDP Field Name</td>
<td>Value</td>
<td>Payer Usage</td>
<td>Payer Situation</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------</td>
<td>---------------------</td>
<td>-------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>RW</td>
<td></td>
<td>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. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>549-7F</td>
<td>HELP DESK PHONE NUMBER QUALIFIER</td>
<td>RW</td>
<td></td>
<td>Imp Guide: Required if Help Desk Phone Number (550-8F) is used. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>550-8F</td>
<td>HELP DESK PHONE NUMBER</td>
<td>RW</td>
<td></td>
<td>Imp Guide: Required if needed to provide a support telephone number to the receiver. Payer Requirement: Same as Imp Guide Note: Help Desk Phone Number may continue to be returned in 526-FQ Additional Message Information field.</td>
</tr>
</tbody>
</table>

**Response Claim Segment Questions**

<table>
<thead>
<tr>
<th>Check</th>
<th>Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>455-EM</td>
<td>PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER</td>
<td>1 = RxBilling</td>
<td>M</td>
<td>Imp Guide: For Transaction Code of “B1”, in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing).</td>
</tr>
<tr>
<td>402-D2</td>
<td>PRESCRIPTION/SERVICE REFERENCE NUMBER</td>
<td></td>
<td>M</td>
<td></td>
</tr>
</tbody>
</table>

**Response DUR/PPS Segment Questions**

<table>
<thead>
<tr>
<th>Check</th>
<th>Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>To be sent if additional information is to be sent to the pharmacy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>567-J6</td>
<td>DUR/PPS RESPONSE CODE COUNTER</td>
<td>Maximum 9 occurrences supported.</td>
<td>RW</td>
<td>Imp Guide: Required if Reason For Service Code (439-E4) is used. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>439-E4</td>
<td>REASON FOR SERVICE CODE</td>
<td>RW</td>
<td></td>
<td>Imp Guide: Required if utilization conflict is detected. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>528-FS</td>
<td>CLINICAL SIGNIFICANCE CODE</td>
<td>RW</td>
<td></td>
<td>Imp Guide: Required if needed to supply additional information for the utilization conflict. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>529-FT</td>
<td>OTHER PHARMACY INDICATOR</td>
<td>RW</td>
<td></td>
<td>Imp Guide: Required if needed to supply additional information for the utilization conflict. Payer Requirement: Same as Imp Guide</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
<td>Access</td>
<td>Imp Guide</td>
<td>Payer Requirement</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>530-FU</td>
<td>PREVIOUS DATE OF FILL</td>
<td>RW</td>
<td>Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used.</td>
<td>Same as Imp Guide</td>
</tr>
<tr>
<td>531-FV</td>
<td>QUANTITY OF PREVIOUS FILL</td>
<td>RW</td>
<td>Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (530-FU) is used.</td>
<td>Same as Imp Guide</td>
</tr>
<tr>
<td>532-FW</td>
<td>DATABASE INDICATOR</td>
<td>RW</td>
<td></td>
<td>Same as Imp Guide</td>
</tr>
<tr>
<td>533-FX</td>
<td>OTHER PRESCRIBER INDICATOR</td>
<td>RW</td>
<td></td>
<td>Same as Imp Guide</td>
</tr>
<tr>
<td>544-FY</td>
<td>DUR FREE TEXT MESSAGE</td>
<td>RW</td>
<td>Required if needed to supply additional information for the utilization conflict.</td>
<td>Same as Imp Guide</td>
</tr>
<tr>
<td>570-NS</td>
<td>DUR ADDITIONAL TEXT</td>
<td>RW</td>
<td>Required if needed to supply additional information for the utilization conflict.</td>
<td>Same as Imp Guide</td>
</tr>
</tbody>
</table>

**Claim Billing/Claim Rebill Rejected/Rejected Response**

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Payer Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>498-PY</td>
<td>PRIOR AUTHORIZATION NUMBER-ASSIGNED</td>
<td>RW</td>
<td>Required when the receiver must submit this Prior Authorization Number in order to receive payment for the claim.</td>
<td>Same as Imp Guide Note: Prior Authorization Number may continue to be returned in 526-FQ Additional Message Information field.</td>
</tr>
</tbody>
</table>

**Response Transaction Header Segment Questions**

- Check
- Claim Billing/Claim Rebill Rejected/Rejected
- If Situational, Payer Situation

- This Segment is always sent

**Response Prior Authorization Segment Questions**

- This Segment is always sent
- This Segment is situational

- Check
- Claim Billing/Claim Rebill Rejected/Rejected
- If Situational, Payer Situation

- To be sent if Prior Authorization information is needed.
## Response Transaction Header Segment

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Claim Billing/Claim Rebill Rejected/Rejected</th>
<th>Payer Situation</th>
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<tbody>
<tr>
<td>102-A2</td>
<td>VERSION/RELEASE NUMBER</td>
<td>DØ</td>
<td>M</td>
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</tr>
<tr>
<td>103-A3</td>
<td>TRANSACTION CODE</td>
<td>B1, B3</td>
<td>M</td>
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<tr>
<td>109-A9</td>
<td>TRANSACTION COUNT</td>
<td>Same value as in request</td>
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</tr>
<tr>
<td>501-F1</td>
<td>HEADER RESPONSE STATUS</td>
<td>R = Rejected</td>
<td>M</td>
<td></td>
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</tr>
<tr>
<td>202-B2</td>
<td>SERVICE PROVIDER ID QUALIFIER</td>
<td>Same value as in request</td>
<td>M</td>
<td></td>
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<tr>
<td>201-B1</td>
<td>SERVICE PROVIDER ID</td>
<td>Same value as in request</td>
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<tr>
<td>401-D1</td>
<td>DATE OF SERVICE</td>
<td>Same value as in request</td>
<td>M</td>
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</table>

### Response Message Segment Questions

- **Check**: This Segment is always sent
- **Claim Billing/Claim Rebill Rejected/Rejected**: If Situational, Payer Situation
- **If additional messaging is needed:** Used if additional messaging is needed.

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Claim Billing/Claim Rebill Rejected/Rejected</th>
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</thead>
<tbody>
<tr>
<td>504-F4</td>
<td>MESSAGE</td>
<td>RW</td>
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</table>

### Response Status Segment Questions

- **Check**: This Segment is situational

<table>
<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
<th>Value</th>
<th>Payer Usage</th>
<th>Claim Billing/Claim Rebill Rejected/Rejected</th>
<th>Payer Situation</th>
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</thead>
<tbody>
<tr>
<td>112-AN</td>
<td>TRANSACTION RESPONSE STATUS</td>
<td>R = Reject</td>
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<td></td>
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</tr>
<tr>
<td>510-FA</td>
<td>REJECT COUNT</td>
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<tr>
<td>511-FB</td>
<td>REJECT CODE</td>
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<td></td>
<td></td>
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<tr>
<td>546-4F</td>
<td>REJECT FIELD OCCURRENCE INDICATOR</td>
<td>RW</td>
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<tr>
<td>130-UF</td>
<td>ADDITIONAL MESSAGE INFORMATION COUNT</td>
<td>Maximum count of 25.</td>
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<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>RW</td>
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<tr>
<td>549-7F</td>
<td>HELP DESK PHONE NUMBER QUALIFIER</td>
<td>RW</td>
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</tbody>
</table>

### Response Status Segment

- **Check**: This Segment is always sent

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<thead>
<tr>
<th>Field #</th>
<th>NCPDP Field Name</th>
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<td>510-FA</td>
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<td>RW</td>
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<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>RW</td>
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<tr>
<td>549-7F</td>
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<td>RW</td>
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<td>Payer Usage</td>
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</table>

**Imp Guide:** Required if needed to provide a support telephone number to the receiver.

**Payer Requirement:** Same as Imp Guide

**Note:** Help Desk Phone Number may continue to be returned in 526-FQ Additional Message Information field.

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