Payer Specification Sheet

Segment and Field Requirements by Transaction Type

BILLING (B1), REVERSAL (B2), REBILL (B3), PA REQUEST and BILLING (P1), PA REVERSAL (P2), PA INQUIRY (P3), PA REQUEST ONLY (P4), ELIGIBILITY VERIFICATION (E1) Transaction Data Elements

M=Mandatory, R= Required, Q=Qualified Requirement, N= Not Used for Transaction, ***R***=Repeating Field

Transaction Header Segment – Mandatory			Required
NCPDP Field	**Field Name**	**Mandatory or Situational**	**COMMENTS/VALUES**
101-A1	BIN NUMBER	M	610706
102-A2	VERSION/RELEASE NUMBER	M	D.0
103-A3	TRANSACTION CODE	M	B1, B2, B3, E1, P1, P2, P3 or P4 only
104-A4	PROCESSOR CONTROL NUMBER	M	WAPROD – Production WATEST- Test
109-A9	TRANSACTION COUNT	M	01 – 04; One Transaction For B2 Or Compound Claims; Up To 4 For B1 Or B3
202-B2	SERVICE PROVIDER ID QUALIFIER	M	01 (NPI)
201-B1	SERVICE PROVIDER ID	M	National Provider Identifier
401-D1	DATE OF SERVICE	M	CCYYMMDD
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	M	Use Value For Switch's Requirements, Or Populate With Blanks

Patient Segment – Situational			**Required for B1, B2, & B3 transactions**
111-AM	SEGMENT IDENTIFICATION	M	01
304-C4	DATE OF BIRTH	M	Required
305-C5	PATIENT GENDER CODE	M	Required
310-CA	PATIENT FIRST NAME	R	Required
311-CB	PATIENT LAST NAME	R	Required
322-CM	PATIENT STREET ADDRESS	N	Not Required - Captured if transmitted
323-CN	PATIENT CITY ADDRESS	N	Not Required - Captured if transmitted
324-CO	PATIENT STATE / PROVINCE ADDRESS	N	Not Required - Captured if transmitted
325-CP	PATIENT ZIP/POSTAL ZONE	N	Not Required - Captured if transmitted
326-CQ	PATIENT PHONE NUMBER	N	Not Required - Captured if transmitted
384-4X	PATIENT RESIDENCE	Q	**01**=Home **02**=Skilled Nursing Facility **11**=Hospice Patient Whose Prescription Is Unrelated To Their Terminal Condition **12**=Psychiatric Residential Treatment Facility (ITA claims)

Insurance Segment – Situational			**Required For B1, B3, P1, P2, P3, P4 And E1 Transactions**
302-C2	CARDHOLDER ID	M	ProviderOne Client ID
306-C6	PATIENT RELATIONSHIP CODE	M	Required 1 = Cardholder

Claim Segment – Mandatory			**Required for B1, B2, B3, P1, P2, P3 & P4**
111-AM	SEGMENT IDENTIFICATION	M	07
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Required 1 = Rx billing
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Required, supports 12digit Rx number
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	02= Health Related Item (HRI) Ø3 = National Drug Code (NDC)
407-D7	PRODUCT/SERVICE ID	M	11-digit NDC or HRI
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER	Q	Required when billing for a partial fill, supports 12-digit prescription number
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	Q	Required when billing for a partial fill
458-SE	PROCEDURE MODIFIER CODE COUNT	N	Required ONLY if Procedure

Claim Segment – Mandatory			Required for B1, B2, B3, P1, P2, P3 & P4
			Modifier Code Submitted
459-ER	PROCEDURE MODIFIER CODE	N	Not Required - Captured if transmitted
442-E7	QUANTITY DISPENSED	Q	Required for B1 & B3 transactions
403-D3	FILL NUMBER	Q	Required for B1 & B3 transactions 0 = Original dispensing 1-99 = Refill Number
405-D5	DAYS SUPPLY	Q	Required for B1 & B3 transactions
406-D6	COMPOUND CODE	Q	Ø2 = Compound See Compound Segment for support of multi-ingredient compounds Required for B1 & B3 compound transactions
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Q	Not Required - Captured if transmitted 1 = Dispense As Written
414-DE	DATE PRESCRIPTION WRITTEN	Q	Required for B1 & B3 transactions
415-DF	NUMBER OF REFILLS AUTHORIZED	N	Not Required – Captured if transmitted
419-DJ	PRESCRIPTION ORIGIN CODE	N	Not Required – Captured if transmitted
420-DK	SUBMISSION CLARIFICATION CODE	Q***R***	**08**=Process Compound for Approved Ingredients
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Q	Required when submitting submission clarification code
308-C8	OTHER COVERAGE CODE	Q	2 = Other coverage exists-payment collected 3 = Other coverage billed-claim not covered 4 = Other coverage exists – payment not collected 8 = Claim is a billing for a patient financial responsibility only- Copay
995-E2	ROUTE OF ADMINISTRATION	N	Not Required – Captured if transmitted
429-DT	SPECIAL PACKAGING INDICATOR	Q	Required, 3 = Pharmacy Unit Dose
453-EJ	ORIG PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	Q	Required on partial or completion fills
445-EA	ORIGINALLY PRESCRIBED	Q	Required on partial or

Claim Segment – Mandatory			Required for B1, B2, B3, P1, P2, P3 & P4
	PRODUCT/SERVICE CODE		completion fills
446-EB	ORIGINALLY PRESCRIBED QUANTITY	Q	Required on partial or completion fills
330-CW	ALTERNATE ID	N	Not Required – Captured if transmitted
454-EK	SCHEDULED PRESCRIPTION ID NUMBER	N	Not Required – Captured if transmitted
600-28	UNIT OF MEASURE	N	Not Required – Captured if transmitted
418-DI	LEVEL OF SERVICE	N	Not Required – Captured if transmitted
461-EU	PRIOR AUTHORIZATION TYPE CODE	Q	2 = Self-Referred Healthy Options Client 5 = Lost or stolen medication replacement 6 = Sterilization 8 = Supply for take home, school or camp, suicide risk or monitoring
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Q	Authorization or Expedited Authorization Number
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID	N	Not Required – Captured if transmitted
464-EX	INTERMEDIARY AUTHORIZATION ID	N	Not Required – Captured if transmitted
343-HD	DISPENSING STATUS	Q	Blank = Not Specified P = Partial Fill C = Completion of Partial Fill
344-HF	QUANTITY INTENDED TO BE DISPENSED	Q	Required on partial or completion fills
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	Q	Required on partial or completion fills

Prescriber Segment – Situational			Required for B1, B3, P1, P2, P3 and P4 transactions
111-AM	SEGMENT IDENTIFICATION	M	03
466-EZ	PRESCRIBER ID QUALIFIER	M	01 = National Provider ID
411-DB	PRESCRIBER ID	M	National Provider ID
427-DR	PRESCRIBER LAST NAME	Q	Required for P1, P2, P3 and P4 transactions
364-2J	PRESCRIBER FIRST NAME	Q	Required for P1, P2, P3 and P4 transactions
498-PM	PRESCRIBER PHONE NUMBER	Q	Required for P1, P2, P3 and P4 transactions

Clinical Segment – Situational			Required For B1, B3, P1, P2, P3, P4 And E1 Transactions
111-AM	SEGMENT IDENTIFICATION	M	
491-VE	DIAGNOSIS CODE COUNT	Q	Prior Authorization Request Only (Claim/Service): Maximum count of 5. Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.
492-WE	DIAGNOSIS CODE QUALIFIER	Q***R***	Prior Authorization Request Only (Claim/Service): Required if Diagnosis Code (424-DO) is used.
424-DO	DIAGNOSIS CODE	Q***R***	Prior Authorization Request Only (Claim/Service): The value for this field is obtained from the prescriber or authorized representative. 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 professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs.
493-XE	CLINICAL INFORMATION COUNTER	Q***R***	Prior Authorization Request Only (Claim/Service): Maximum of 5 occurrences supported. Grouped with Measurement fields (Measurement Date (494-ZE), Measurement Time (495-H1), Measurement Dimension (496-H2), Measurement Unit (497-H3), Measurement Value (499-H4).
494-ZE	MEASUREMENT DATE	Q***R***	Prior Authorization Request Only (Claim/Service): Required if necessary when this field could result in different coverage and/or drug utilization review outcome.

Clinical Segment – Situational			Required For B1, B3, P1, P2, P3, P4 And E1 Transactions
495-H1	MEASUREMENT TIME	Q***R***	Prior Authorization Request Only (Claim/Service): Required if Time is known or has impact on measurement. Required if necessary when this field could result in different coverage and/or drug utilization review outcome and is a requirement for authorization.
496-H2	MEASUREMENT DIMENSION	Q***R***	Prior Authorization Request Only (Claim/Service): Required if Measurement Unit (497-H3) and Measurement Value (499-H4) are used. Required if necessary when this field could result in different coverage and/or drug utilization review outcome and is a requirement for authorization. Required if necessary for patient's weight and height when billing Medicare for a claim that includes a Certificate of Medical Necessity (CMN).
497-H3	MEASUREMENT UNIT	Q***R***	Prior Authorization Request Only (Claim/Service): Required if Measurement Dimension (496-H2) and Measurement Value (499-H4) are used. Required if necessary for patient's weight and height when billing Medicare for a claim that includes a Certificate of Medical Necessity (CMN). Required if necessary when this field could result in different coverage and/or drug utilization review outcome and is a requirement for authorization.
499-H4	MEASUREMENT VALUE	Q***R***	Prior Authorization Request Only (Claim/Service): Required if Measurement

Clinical Segment – Situational			Required For B1, B3, P1, P2, P3, P4 And E1 Transactions
			Dimension (496-H2) and Measurement Unit (497-H3) are used. Required if necessary for patient's weight and height when billing Medicare for a claim that includes a Certificate of Medical Necessity (CMN). Required if necessary when this field could result in different coverage and/or drug utilization review outcome and is a requirement for authorization.

COB/Other Payments Segment – Situational			Required ONLY for COB processing
111-AM	SEGMENT IDENTIFICATION	M	05
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	M	Required if Segment is Used Maximum = 9
338-5C	OTHER PAYER COVERAGE TYPE	M***R***	01 = Primary 02 = Secondary 03 = Tertiary
339-6C	OTHER PAYER ID QUALIFIER	Q***R***	Blank = Not Specified 01 = National Payer ID 02 = Health Industry Number (HIN) 03 = Bank Information Number (BIN) 04 = National Association of Insurance Commissioners (NAIC) 05=Medicare Carrier Number 99 = Other
340-7C	OTHER PAYER ID	Q***R***	Required if Segment is Used
443-E8	OTHER PAYER DATE	Q***R***	Required, CCYYMMDD
341-HB	OTHER PAYER AMOUNT PAID COUNT	M	Required if Segment is Used
431-DV	OTHER PAYER AMOUNT PAID	Q***R***	Required if Segment is Used

COB/Other Payments Segment – Situational			Required ONLY for COB processing
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Q***R***	Blank = Not Specified 01 = Delivery 02 = Shipping 03 = Postage 04 = Administrative 05 = Incentive 06 = Cognitive Service 07 = Drug Benefit
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Q	Maximum count of 25. Required if submitting other coverage code of 8. Required when Other Payer-Patient Responsibility Amount Qualifier (351-NP) is use.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Q***R***	Required if submitting other coverage code of 8. Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	Q***R***	Required if submitting other coverage code of 8. Required if necessary for patient financial responsibility only billing.

DUR/PPS Segment – Situational			Segment is Not Required, use encouraged if applicable
111-AM	SEGMENT IDENTIFICATION	M	08
473-7E	DUR/PPS CODE COUNTER	Q***R***	Required if segment used, one to 9 occurrences are supported
439-E4	REASON FOR SERVICE CODE	Q***R***	Required if segment used AD = Additional Drug Needed AN = Prescription Authentication AR = Adverse Drug Reaction AT = Additive Toxicity CD = Chronic Disease Management CH = Call Help Desk CS = Patient Complaint/Symptom DA = Drug Allergy DC = Drug disease (inferred) DD = Drug-drug interaction DF = Drug-food interaction DI = Drug Incompatibility

DUR/PPS Segment – Situational			Segment is Not Required, use encouraged if applicable
439-E4	REASON FOR SERVICE CODE	Q***R***	DL = Drug-lab conflict DM = Apparent Drug Misuse DR – Dose Range Conflict DS = Tobacco Use ED = Patient Education/Instruction ER = Overuse EX = Excessive Quantity HD = High dose IC = Iatrogenic condition ID = Ingredient duplication LD = Low Dose LK = Lock In Recipient LR = Underuse MC = Drug disease (Reported) MN = Insufficient duration MS = Missing Information/Clarification MX = Excessive duration NA = Drug not available NC = Non-covered drug purchase ND = New disease/diagnosis NF = Non-formulary drug NN = Unnecessary drug NP = New Patient processing NR = Lactation/Nursing interaction NS = Insufficient quantity OH = Alcohol conflict AP = Drug Age PC = Patient question/concern PG = Drug pregnancy PH = Preventative Health Care PN = Prescriber consultation PP = Plan protocol PR = Prior adverse reaction PS = Product selection opportunity RE = Suspected environmental risk RF = Health Provider referral SC = Suboptimal compliance SD = Suboptimal drug/indication SE = Side Effect SF = Suboptimal dosage form SR = Suboptimal regimen SX = Drug gender

DUR/PPS Segment – Situational			Segment is Not Required, use encouraged if applicable
439-E4	REASON FOR SERVICE CODE	Q***R***	TD = Therapeutic duplication TN = Laboratory test needed TP = Payer/Processor question UD – Duplicate Drug
440-E5	PROFESSIONAL SERVICE CODE	Q***R***	Required if segment used M0 (M, zero) = Prescriber consulted P0 (P, zero) = Patient consulted R0 (R, zero) = Pharmacist consulted other source

DUR/PPS Segment – Situational			Segment is Not Required, use encouraged if applicable
441-E6	RESULT OF SERVICE CODE	Q***R***	Required if segment used 00 = Not specified 1A = Filled as is, false positive 1B = Filled as is 1C = Filled with different dose (Override a refill to soon edit for a dosage change) 1D = Filled with different directions 1E = Filled with different drug 1F = Filled with different quantity 1G = Filled after prescriber approval obtained 1H = Brand-to-Generic change 1J = Rx-to-OTC change 1K = Filled with different dosage form 2A = Prescription not filled 2B = Not filled, directions clarified 3A = Recommendation accepted 3B = Recommendation not accepted 3C = Discontinued drug 3D = Regimen changed 3E = Therapy changed 3F = Therapy changed-cost increased acknowledged 3G = Drg therapy unchanged 3H = Follow up/report 3J = Patient referral 3K = Instructions understood 3M = Compliance aid provided 3N = Medication administered 4A – Prescribed with acknowledgements

Pricing Segment – Mandatory			Required for B1 & B3 transactions
111-AM	SEGMENT IDENTIFICATION	M	11
409-D9	INGREDIENT COST SUBMITTED	M	Required
412-DC	DISPENSING FEE SUBMITTED	N	Not Required - Captured if transmitted

Pricing Segment – Mandatory			Required for B1 & B3 transactions
433-DX	PATIENT PAID AMOUNT SUBMITTED	N	Not Required - Captured if transmitted
438-E3	INCENTIVE AMOUNT SUBMITTED	N	Not Required - Captured if transmitted
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	N	Not Required - Captured if transmitted
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	Q***R***	Not Required - Captured if transmitted
481-HA	FLAT SALES TAX AMOUNT SUBMITTED	N	Not Required - Captured if transmitted
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED	N	Not Required - Captured if transmitted
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	N	Not Required - Captured if transmitted
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	N	Not Required - Captured if transmitted
426-DQ	USUAL AND CUSTOMARY CHARGE	M	Required Amount charged cash customers for the prescription exclusive of sales tax For Public Health Service entities, usual and customary charge is the ‘actual acquisition cost’
430-DU	GROSS AMOUNT DUE	M	Required
423-DN	BASIS OF COST DETERMINATION	N	Not Required - Captured if transmitted

Compound Segment – Situational			Required for compound claims
111-AM	SEGMENT IDENTIFICATION	M	10
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	M	Required 01 = Capsule 02 = Ointment 03 = Cream 04 = Suppository 05 = Powder 06 = Emulsion 07 = Liquid 10 = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup

Compound Segment – Situational			Required for compound claims
			17 = Lozenge 18 = Enema
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	M	1 = Each 2 = Grams 3 = Milliliters
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M***R***	Count Of Compound Product ID's (NDC's)
488-RE	COMPOUND PRODUCT ID QUALIFIER	M***R***	03 = NDC
489-TE	COMPOUND PRODUCT ID	M***R***	11-Digit NDC
448-ED	COMPOUND INGREDIENT QUANTITY	M***R***	Required
449-EE	COMPOUND INGREDIENT DRUG COST	M	Required When A Compound Drug Is Dispensed
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	M	Required When A Compound Drug Is Dispensed

Prior Authorization Segment – Situational			Required for P1, P2, P3, P4 transaction
111-AM	SEGMENT IDENTIFICATION	M	12
498-PA	REQUEST TYPE	M	1 = Initial 2 = Reauthorization 3 = Deferral
498-PB	REQUEST PERIOD DATE-BEGIN	M	CCYYMMDD
498-PC	REQUEST PERIOD DATE-END	M	CCYYMMDD
498-PD	BASIS OF REQUEST	M	ME = Medical Exception PR = Plan Requirement PL = Increase Plan Limitation
498-PY	PRIOR AUTHORIZATION NUMBER-ASSIGNED	Q	Required for P2 transactions

Note: A "Situational" data element means the NCPDP Standard does **not** require data on all claims, but the PLAN SPONSOR reserves the possibility of use in specific claim situations. The "Mandatory", "Required" and "Qualified Requirement" fields within "Situational" segments are only mandatory IF the segment is being utilized.