Pharmacy Encounter
Companion Guide
NCPDP versions 1.2 and Transaction version D.0 (Request)
State of Washington

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WAMMIS-CG-PENC-D.0-01-07

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Disclaimer

This companion guide for the NCPDP D.0 Encounters transaction has been created for use in conjunction with the standard Implementation Guide. It should not be considered a replacement for the Implementation Guide, but rather used as an additional source of information. The companion guide contains data clarifications derived from specific business rules that apply exclusively to Medicaid processing for Washington State. The guide also includes useful information about sending and receiving data to and from the ProviderOne system.

Revision History

Documented revisions are maintained in this document through the use of the Revision History Table shown below. All revisions made to this companion guide after the creation date are noted along with the date, page affected, and reason for the change.

Revision Level	Date	Page	Description	Change Summary
WAMMIS-CG-PENC-D.0-01-01	04/01/2012		Final D.0 Version	
WAMMIS-CG-PENC-D.O-01-02	03/17/2012		Update element requirement.	Updated 409-D9 from an optional to a mandatory element
WAMMIS-CG-PENC-D.O-01-03	01/06/2017		Updated element description use	Updated 308-C8 to include additional coverage codes Updated 338-5C to include additional Other Payer Coverage Types Updated 340-7C Other Payer ID to allow for other payer names Updated 431-DV Other Payer Amount Paid to allow for other payer paid amounts.
WAMMIS-CG-PENC-D.O-01-04	2/13/2017		Updated element description use	Updated 338-5C. Only value allowed currently is 01-Primary
WAMMIS-CG-PENC-D.O-01-05	08/28/2019		Update URL	Update URL
WAMMIS-CG-PENC-D.O-01-06	03/02/2020		Adding Field Numbers and Segment Names	Added: 461-EU PRIOR AUTHORIZATION TYPE CODE 462-EV PRIOR AUTHORIZATION NUMBER SUBMITTED 424-DO DIAGNOSIS CODE 443-E8 OTHER PAYER DATE 353-NR OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT 351-NP OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT

				QUALIFIER 352-NQ OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT 439-E4 REASONFOR SERVICE CODE 440-E5 PROFESSIONAL SERVICE CODE 441-E6 RESULT OF SERVICE CODE 438-E3 INCENTIVE AMOUNT SUBMITTED 478-H7 OTHER AMOUNT CLAIMED SUBMITTED COUNT
WAMMIS-CG-PENC-D.O-01-07 Draft Version 1 (V1)	06/2022		Update to add new NCPDP fields and change 2 existing fields – Draft changes	**Additions** Segment Identifier 23 including fields: 501-F1 Header Response Status 409-Z8 Allowed Ingredient Amount 509-F9 Total Amount Paid 399-Z3 Record Status Code 203-Z4 Adjudication Time 578-Z5 Adjudication Date 510-FA Reject Count 511-FB Reject Code 257-Z9 Formulary Status 833-5P Pharmacy Name **Changes** Segment Identifier 11 including field definitions for: 426-DQ Usual and Customary Charge 426-DU Gross Amount Due
WAMMIS-CG-PENC-D.O-01-07 Draft Version 2 (V2)	10/2022		Updated definitions – Draft changes	Updated 426-DQ and ~~426~~430-DU to reflect accurate definitions. Change location of field 833-5P from Response Pricing Segment to right after 501-F1 in the Header Response

				Status to align with system specifications.
WAMMIS-CG-PENC-D.O-01-07 Draft Version 3 (V3)	01/2023			Update to spelling in the above change summary. 426-DU should be 430-DU
WAMMIS-CG-PENC-D.O-01-07 Draft Version 4 (V4)	04/2023			Changed BIN Number to 024822 Updated Segment 23: User Option changed to "Must Use" Updated 409-Z8 to Overpunch pricing Added Notes to: 509-F9 510-FA 511-FB 409-Z8
WAMMIS-CG-PENC-D.O-01-07 Draft Version 5 (V5)	07/2023			Adding Segment 23 to B2 Transaction Layout. Updated Segment B1, B2 and B3 Transaction Layouts from "Use" to Must use".

Contents

Introduction

- NCPDP Version 1.2 defines the data structure and content of batch pharmacy transmissions only.
- NCPDP Version D.0 defines the data structure and content of single Point-of-Sale (POS) transmissions only.

These specifications cover the minimum required fields (mandatory) per the NCPDP Versions 1.2 and D.0 standards as well as the required fields needed for the State of Washington Health Care Authority encounter claims processing.

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) includes requirements that national standards be established for electronic health care transactions, and national identifiers for providers, health plans, and employers. This requires Washington State Health Care Authority (HCA) to adopt standards to support the electronic exchange of administrative and financial health care transactions between covered entities (health care providers, health plans, and healthcare clearinghouses).

The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care. The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were not imposed arbitrarily but were developed by processes that included significant public and private sector input.

Encounters are not HIPAA named transactions and the NCPDP Version D.0 Implementation Guide was used as a foundation to construct the standardized HCA encounter reporting process.

Document Purpose

Companion Guides are used to clarify the exchange of information on NCPDP Encounter transactions between the HCA ProviderOne system and its trading partners. HCA defines trading partners as covered entities that either submit or retrieve NCPDP batch transactions to and from ProviderOne.

This Companion Guide provides information related to electronic submission of NCPDP Encounter Transactions to HCA by approved trading partners.

This Companion Guide is intended for trading partner use in conjunction with the NCPDP Batch Standard Implementation Guide Version 1 Release 2 The NCPDP Implementation Guides can be accessed at http://www.ncpdp.org/.

Intended Users

Companion Guides are intended to be used by members/technical staff of trading partners who are responsible for electronic transaction/file exchanges.

Relationship to NCPDP Implementation Guides

Companion Guides are intended to supplement the NCPDP Implementation Guides for NCPDP transactions. Rules for format, content, and field values can be found in the Implementation Guides. This Companion Guide describes the technical interface environment with HCA, including connectivity requirements and protocols, and electronic interchange procedures. This guide also provides specific information on data elements and the values required for transactions sent to or received from HCA.

Companion Guides are intended to supplement rather than replace the standard Implementation Guide for each transaction set. The information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

Transmission Schedule

N/A

Technical Infrastructure and Procedures

Technical Environment

Communication Requirements

This section will describe how trading partners can send NCPDP Transactions to HCA using:

- Secure File Transfer Protocol (SFTP)

Testing Process

Completion of the testing process must occur prior to submitting electronic transactions in production to ProviderOne. Testing is conducted to ensure the following levels of NCPDP compliance:

1. Level 1 – Syntactical integrity: Testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 or NCPDP syntax, and compliance with X12 and NCPDP rules.
2. Level 2 – Syntactical requirements: Testing for NCPDP Implementation Guide-specific syntax requirements, such as limits on repeat counts, used and not used qualifiers, codes, elements and segments. It will also include testing for NCPDP HIPAA required or intra-segment situational data elements.

Additional testing may be required in the future to verify any changes made to the ProviderOne system. Changes to the ANSI formats may also require additional testing. Assistance is available throughout the testing process.

Trading Partner Testing Procedures

1. ProviderOne companion guides and the trading partner enrollment package are available for download via the web at https://www.hca.wa.gov/CG_HIPAA

2. The Trading Partner completes the Trading Partner Agreement and submits the signed agreement to DSHS.

   Submit to: HCA HIPAA EDI Department
   626 8th Avenue SE
   PO Box 45564
   Olympia, WA 98504-5564

   For Questions call 1-800-562-3022 extension ‘16137’

3. The trading partner is assigned a Submitter ID, Domain, Logon User ID and password.
4. The trading partner submits all NCPDP test files through the Secure File Transfer Protocol (SFTP).

- SFTP URL: ftp.waproviderone.org

5. The trading partner downloads acknowledgements for the test file from the ProviderOne SFTP site.
6. If the ProviderOne system generates a positive acknowledgment, the file is successfully accepted. The trading partner is then approved to send NCPDP Encounter files in production.
7. If the test file generates a negative acknowledgment, then the submission is unsuccessful, and the file is rejected. The trading partner needs to resolve all the errors that are reported on the negative acknowledgment and resubmit the file for test. Trading partners will continue to test in the testing environment until they receive a positive acknowledgment.

Who to contact for assistance

- Email: HIPAA-help@hca.wa.gov
  - All emails result in the assignment of a Ticket Number for problem tracking
- Information required for initial email:
  - Name
  - Phone Number
  - Email Address
  - 7 Digit Domain/ProviderOne ID
  - Transaction you are inquiring about
  - File Name
  - Detailed description of concern
- Information required for follow up call(s):
  - Assigned Ticket Number

Set-up, Directory, and File Naming Convention

SFTP Set-up

Trading partners can contact HIPAA-Help@hca.wa.gov for information on establishing connections through the FTP server. Upon completion of set-up, they will receive additional instructions on FTP usage.

SFTP Directory Naming Convention

There would be two categories of folders under Trading Partner's SFPT folders:

1. **TEST – Trading Partners should submit and receive their test files under this root folder**

2. **PROD – Trading Partners should submit and receive their production files under this root folder**

Following folder will be available under TEST/PROD folder within SFTP root of the Trading Partner:

'NCPDP_Inbound' - This folder should be used to drop the Inbound files that needs to be submitted to HCA

'NCPDP_Ack' - Trading partner should look for acknowledgements to the files submitted in this folder. Custom error report will be available for all the files submitted by the Trading Partner

'NCPDP_Outbound' – X12 outbound transactions generated by HCA will be available in this folder

'NCPDP_Error' – Any inbound file that is not HIPAA/NCPDP compliant or is not recognized by ProviderOne will be moved to this folder

Folder Structure will appear as:

- **PROD**
  - **NCPDP Inbound**
  - **NCPDP Error**
  - **NCPDP Outbound**
  - **NCPDP_Ack**
- **TEST**
  - **NCPDP Inbound**
  - **NCPDP Error**
  - **NCPDP Outbound**
  - **NCPDP_Ack**

File Naming Convention

The HIPAA Subsystem Package is responsible for assisting ProviderOne activities related to Electronic Transfer and processing of Health Care and Health Encounter Data, with a few exceptions or limitations.

NCPDP files are named:

For Inbound transactions:

NCPDP.<TPId>.<datetimestamp>.<originalfilename>.<dat>

Example of file name: NCPDP.101721500.122620072100_P_1.dat

- <TPId> is the Trading Partner Id
- <datetimestamp> is the Date timestamp
- <originalfilename> is the original file name which is submitted by the trading partner.

Transaction Standards

General Information

NCPDP standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda,

An overview of requirements specific to the NCPDP batch transactions can be found in the NCPDP Batch Standard and Batch Implementation Guide Version 1 Release 2. Implementation Guides contain information related to:

- Format and content of batch and transaction group
- Format and content of the header, detail and trailer segments specific to the batch
- Code sets and values authorized for use in the transaction
- Allowed exceptions to specific transaction requirements

Transmission sizes are limited based on two factors:

- Number of Segments/Records allowed by NCPDP Standards
- HCA file size limitations

HCA limits a file size to 100 MB through SFTP.

General file layout

NCPDP 1.2 Batch layout:

ID	Name	Req	Usage	Min Use	Max Use
00	Transmission Header	Mandatory	Must use	1	1
G1	Transaction Detail	Optional	Used	1	999999
99	Transmission Trailer	Mandatory	Must use	1	1

NCPDP D.0 B1 Transaction layout:

Pos	ID	Name	Opt	RP/#	Usage
1	TH	Transaction Header	M		Must use
2	01	Patient	O		Used
3	04	Insurance	M		Must use
4	**{**	**Claim Billing**	**M**	**4**	**Must use**
5	07	Claim	M		Must use
7	03	Prescriber	O		Used
8	05	COB/Other Payments	O		Used
10	08	DUR/PPS	O		Used
11	11	Pricing	M		Must use
13	10	Compound	O		Used
14	13	Clinical	O		Used
18	23	Response Pricing	O		Must use
	}				

NCPDP D.0 B2 Transaction layout:

Pos	ID	Name	Opt	RP/#	Usage
1	TH	Transaction Header	M		Must use
2	04	Insurance	O		Used
3	**{**	**Claim Reversal**	**M**	**4**	**Must use**
4	07	Claim	M		Must use
5	05	COB/Other Payments	O		Used
6	08	DUR/PPS	O		Used
7	11	Pricing	O		Used
18	23	Response Pricing	O		Must use
	}				

NCPDP D.0 B3 Transaction layout:

Pos	ID	Name	Opt	RP/#	Usage
1	TH	Transaction Header	M		Must use
2	01	Patient	O		Used
3	04	Insurance	M		Must use
4	**{**	**Claim Billing**	**M**	**4**	**Must use**
5	07	Claim	M		Must use
7	03	Prescriber	O		Used
8	05	COB/Other Payments	O		Used
10	08	DUR/PPS	O		Used
11	11	Pricing	M		Must use
13	10	Compound	O		Used
14	13	Clinical	O		Used
18	23	Response Pricing	O		Must use
	}				

00

Transmission Header

Min Use: 1 **Mandatory** **Grp:** **Max Use: 1** **Fields: 11**

User Option (Usage): Must use

Pos	ID	FIELD	Type	Justify	Len	Size	Start	End	Occurs
01	**880-K4**	**Text Indicator**	String	Left	1	1	1	1	1
		Format: X(1) **Purpose:** This field is used to identify the beginning and ending of the data record. **ProviderOne Companion Guide Rules D.0:** Start of Text (STX) = X'02'							
02	**701**	**Segment Identifier**	String	Left	2	2	2	3	1
		Format: X(2) **Purpose:** Unique record type required on Enrollment/Batch Transaction Standard. **ProviderOne Companion Guide Rules D.0:** Use '00'							
03	**880-K6**	**Transmission Type**	String	Left	1	1	4	4	1
		Format: X(1) **Purpose:** A value to define the type of transmission being sent. **ProviderOne Companion Guide Rules D.0:** Use:T = Transaction							
04	**880-K1**	**Sender ID**	String	Left	24	24	5	28	1
		Format: X(24) **Purpose:** An identification number assigned to the sender of the data by the processor/receiver of the data. **ProviderOne Companion Guide Rules D.0:** Enter the MCO's 9 digit program specific ProviderOne ID e.g. '123456700'							
05	**806-5C**	**Batch Number**	Explicit Sign Number	Right	7	7	29	35	1
		Format: 9(7) **Purpose:** This number is assigned by the processor/sender. **ProviderOne Companion Guide Rules D.0:** Must match the Trailer Batch Number							
06	**880-K2**	**Creation Date**	Explicit Sign Number	Right	8	8	36	43	1
		Format: 9(8) **Purpose:** Date the file was created. **ProviderOne Companion Guide Rules D.0:** Enter date in CCYYMMDD format e.g., 20090401 for April 1st **2009**							
07	**880-K3**	**Creation Time**	Explicit Sign Number	Right	4	4	44	47	1
		Format: 9(4) **Purpose:** Time the file was created.							

ProviderOne Companion Guide Rules D.0:
Enter time in HHMM format e.g. 2030 for 8:30 pm

08	**702**	**File Type**	String	Left	1	1		48	48	1

Format: X(1)
Purpose: Code identifying whether the file contained is test or production data.
ProviderOne Companion Guide Rules D.0:
Use 'T' when submitting a Test File
Use 'P' when submitting a Production File

09	**102-A2**	**Version/Release Number**	String	Left	2	2		49	50	1

Format: X(2)
Purpose: Code uniquely identifying the transmission syntax and corresponding Data Dictionary.
ProviderOne Companion Guide Rules D.0:
Use '12'

10	**880-K7**	**Reciever ID**	String	Left	24	24		51	74	1

Format: X(24)
Purpose: An identification number of the endpoint receiver of the data file.
ProviderOne Companion Guide Rules D.0:
Enter '77045' followed by spaces

11	**880-K4**	**Text Indicator**	String	Left	1	1		75	75	1

Format: X(1)
Purpose: This field is used to identify the beginning and ending of the data record.
ProviderOne Companion Guide Rules D.0: End of Text(ETX) = X'03'

G1

Transaction Detail

Min Use: 1
Optional
Grp:

Max U
999
Fields

User Option (Usage): Used

Pos	ID	FIELD	Type	Justify	Len	Size	Start	End	Occurs
01	**880-K4**	**Text Indicator**	String	Left	1	1	1	1	1

Format: X(1)
Purpose: This field is used to identify the beginning and ending of the data record.
ProviderOne Companion Guide Rules D.0: Start of Text (STX) = X'02'

02	**701**	**Segment Identifier**	String	Left	2	2	2	3	1

Format: X(2)
Purpose: Unique record type required on Enrollment/Batch Transaction Standard.
ProviderOne Companion Guide Rules D.0:
Use 'G1' Detail Data Record Start

03	**880-K5**	**Transaction Reference Number**	String	Left	10	10	4	13	1

Format: X(10)
Purpose: A reference number assigned by the claim provider to each of the data records in the batch. The purpose of this number is to facilitate the process of matching the claim response to the claim. The transaction reference number assigned to the claim is to be returned with the claim's corresponding reference number.
ProviderOne Companion Guide Rules D.0:
This number is assigned by the MCO to uniquely identify each claim within the file.

04	**NCPDPDR**	**NCPDP Data Record**	String	Left	9999999	9999999	14	10000012	1

Format: X(9999999)

05	**880-K4**	**Text Indicator**	String	Left	1	1	100000	100000	1

13	13

Format: X(1)
Purpose: This field is used to identify the beginning and ending of the data record.
ProviderOne Companion Guide Rules D.0: End of Text(ETX) = X'03'

99 Transmission Trailer

Min Use: 1 Mandatory Grp: | Max Use: 1 | Fields: 6

User Option (Usage): Must use

Pos	ID	FIELD	Type	Justify	Len	Size	Start	End	Occurs
01	**880-K4**	**Text Indicator**	String	Left	1	1	1	1	1
		Format: X(1) **Purpose:** This field is used to identify the beginning and ending of the data record. **ProviderOne Companion Guide Rules D.0:** Start of Text (STX) = X'02'							
02	**701**	**Segment Identifier**	String	Left	2	2	2	3	1
		Format: X(2) **Purpose:** Unique record type required on Enrollment/Batch Transaction Standard. **ProviderOne Companion Guide Rules D.0:** Use '99'							
03	**806-5C**	**Batch Number**	Explicit Sign Number	Right	7	7	4	10	1
		Format: 9(7) **Purpose:** This number is assigned by the processor/sender. **ProviderOne Companion Guide Rules D.0:** Must match the Header Batch Number							
04	**751**	**Record Count**	Explicit Sign Number	Right	10	10	11	20	1
		Format: 9(10) **Purpose:** Record count within submitted enrollment batch files. This count will be a different value depending upon the enrollment segment in which this count is kept.							
06	**880-K4**	**Text Indicator**	String	Left	1	1	56	56	1
		Format: X(1) **Purpose:** This field is used to identify the beginning and ending of the data record. **ProviderOne Companion Guide Rules D.0:** End of Text (ETX) = X'03'							

TH Transaction Header

POS: 1 Mandatory Transaction: | RP#: 1 | Fields: 9

User Option (Usage): Must use

Field ID	Name	Len	Format	DT	Rep	Req	Usage
101-A1	BIN Number	6	9(6)	N		M	Must use
	Definition: Card Issuer ID or Bank ID Number used for network routing. **ProviderOne Companion Guide Rules D.0:** *Use '024822'*						
102-A2	Version/Release Number	2	x(2)	A/N		M	Must use
	Definition: Code uniquely identifying the transmission syntax and corresponding Data Dictionary. **ProviderOne Companion Guide Rules D.0:** *Use 'D0'*						
103-A3	Transaction Code	2	x(2)	A/N		M	Must use
	Definition: Code identifying the type of transaction. **ProviderOne Companion Guide Rules D.0:**						

	Please use: *B1 - Billing* *B2 - Reversal* *B3 - Rebill*					
104-A4	Processor Control Number	10	x(10)	A/N	M	Must use
	Definition: Number assigned by the processor.					
	ProviderOne Companion Guide Rules D.0: *Please use:* *'ENCOUNTER' for Production files* *'ENCTEST' for Test files*					
109-A9	Transaction Count	1	x(1)	A/N	M	Must use
	Definition: Count of transactions in the transmission.					
	ProviderOne Companion Guide Rules D.0: *Please use:* *1 - One transactions* *2 - Two transactions* *3 - Three transactions* *4 - Four transactions*					
202-B2	Service Provider ID Qualifier				M	Must use
202-B2	Service Provider ID Qualifier	2	x(2)	A/N	M	Must use
	Definition: Code qualifying the 'Service Provider ID' (201-B1).					
	ProviderOne Companion Guide Rules D.0: *Use '01'*					
201-B1	Service Provider ID	15	x(15)	A/N	M	Must use
	Definition: ID assigned to a pharmacy or provider.					
	ProviderOne Companion Guide Rules D.0: *Enter the NPI of the servicing Pharmacy*					
401-D1	Date Of Service	8	9(8)	N	M	Must use
	Definition: Identifies date the prescription (was filled) or (professional service rendered) or (subsequent payer began coverage following Part A expiration in a long-term care setting only).					
	ProviderOne Companion Guide Rules D.0: *Enter date in CCYYMMDD format e.g. 20090401 for April 1st **2009***					
110-AK	Software Vendor/Certification ID	10	x(10)	A/N	M	Must use
	Definition: ID assigned by the switch or processor to identify the software source.					
	ProviderOne Companion Guide Rules D.0: *Use '0000000000'*					

01 Patient

POS: 2 **Optional** **Transaction:**

RP#: 1

Fields: 18

User Option (Usage): Used

Field ID	Name	Len	Format	DT	Rep	Req	Usage
111-AM	Segment Identification	2	x(2)	A/N		M	Must use
	Definition: Identifies the segment in the request and/or response.						
	ProviderOne Companion Guide Rules D.0: *Use '01'*						
331-CX	Patient ID Qualifier					O	Used
331-CX	Patient ID Qualifier	2	x(2)	A/N		M	Must use
	Definition: Code qualifying the 'Patient ID' (332-CY).						
	ProviderOne Companion Guide Rules D.0: *Use '06'*						
332-CY	Patient ID	20	x(20)	A/N		M	Must use
	Definition: ID assigned to the patient.						
	ProviderOne Companion Guide Rules D.0: *Use ProviderOne Client ID e.g. 123456789WA*						
304-C4	Date Of Birth	8	9(8)	N		O	Must use
	Definition: Date of birth of patient.						
	ProviderOne Companion Guide Rules D.0: *Enter date in CCYYMMDD format e.g. 20090401 for April 1st* ***2009***						
305-C5	Patient Gender Code	1	9(1)	N		O	Must use
	Definition: Code indicating the gender of the individual.						
	ProviderOne Companion Guide Rules D.0: *Please use:* *0 - Not specified* *1 - Male* *2 - Female*						
310-CA	Patient First Name	12	x(12)	A/N		O	Used
	Definition: Individual first name.						
	ProviderOne Companion Guide Rules D.0: *Enter Patient First Name*						
311-CB	Patient Last Name	15	x(15)	A/N		O	Must use
	Definition: Individual last name.						
	ProviderOne Companion Guide Rules D.0: *Enter Patient Last Name*						
307-C7	Place of Service	2	9(2)	N		O	Used
	Definition: Code identifying the place where a drug or service is dispensed or administered.						
	ProviderOne Companion Guide Rules D.0: *As per External Code List under D.0*						
384-4X	Patient Residence	2	9(2)	N		O	Used
	Definition: Code identifying the patient's place of residence.						
	ProviderOne Companion Guide Rules D.0: *As per External Code List under D.0*						

04 Insurance

POS: 3
Mandatory
Transaction:

RP#: 1

Fields: 20

User Option (Usage): Must use

Field ID	Name	Len	Format	DT	Rep	Req	Usage
111-AM	Segment Identification	2	x(2)	A/N		M	Must use
	Definition: Identifies the segment in the request and/or response.						
	ProviderOne Companion Guide Rules D.0: *Use '04'*						
302-C2	Cardholder ID	20	x(20)	A/N		M	Must use
	Definition: Insurance ID assigned to the cardholder or identification number used by the plan.						
	ProviderOne Companion Guide Rules D.0: *Use ProviderOne Client ID e.g. 123456789WA*						
306-C6	Patient Relationship Code	1	9(1)	N		O	Used
	Definition: Code indicating relationship of patient to cardholder.						
	ProviderOne Companion Guide Rules D.0: *Please use:* *1 = Cardholder*						

07 Claim

POS: 5
Mandatory
Transaction: B1

RP#: 1

Fields: 43

User Option (Usage): Must use

Field ID	Name	Len	Format	DT	Rep	Req	Usage
111-AM	Segment Identification	2	x(2)	A/N		M	Must use
	Definition: Identifies the segment in the request and/or response.						
	ProviderOne Companion Guide Rules D.0: *Use '07'*						
455-EM	Prescription/Service Reference Number Qualifier					M	Must use
455-EM	Prescription/Service Reference Number Qualifier	1	x(1)	A/N		M	Must use
	Definition: Indicates the type of billing submitted.						
	ProviderOne Companion Guide Rules D.0: *Please use:* *1 = Rx Billing (Paid by MCO)*						
402-D2	Prescription/Service Reference Number	12	9(12)	N		M	Must use
	Definition: Reference number assigned by the provider for the dispensed drug/product and/or service provided.						
	ProviderOne Companion Guide Rules D.0: *Enter the Prescription Number*						
436-E1	Product/Service ID Qualifier					M	Must use
436-E1	Product/Service ID Qualifier	2	x(2)	A/N		M	Must use
	Definition: Code qualifying the value in 'Product/Service ID' (407-D7).						

	ProviderOne Companion Guide Rules D.0: *Please use:* *03 = National Drug Code*					
407-D7	Product/Service ID	19	x(19)	A/N	M	Must use
	Definition: ID of the product dispensed or service provided. **ProviderOne Companion Guide Rules D.0:** *Format=MMMMMDDDDPP MMMMM=Manufacturer's Assigned Number* *DDDD=Drug ID* *PP=Package Size* *Enter 11 Digit NDC Number from Medi-Span*					
442-E7	Quantity Dispensed	10	9(7)v999	N	O	Must use
	Definition: Quantity dispensed expressed in metric decimal units. **ProviderOne Companion Guide Rules D.0:** *Format=9999999.999* *Enter the quantity in numeric e.g., 30 units should be coded as 0000030000*					
403-D3	Fill Number	2	9(2)	N	O	Must use
	Definition: The code indicating whether the prescription is an original or a refill. **ProviderOne Companion Guide Rules D.0:** *Please use:* *0=Original fill* *1-99=Refill Number*					
405-D5	Days Supply	3	9(3)	N	O	Must use
	Definition: Estimated number of days the prescription will last. **ProviderOne Companion Guide Rules D.0:** *Enter number of Days Supply*					
406-D6	Compound Code	1	9(1)	N	O	Must use
	Definition: Code indicating whether or not the prescription is a compound. **ProviderOne Companion Guide Rules D.0:** *Enter:* *0 = Not specified* *1 = Not a compound* *2 = Compound*					
408-D8	Dispense As Written (DAW)/Product Selection Code	1	x(1)	A/N	O	Must use
	Definition: Code indicating whether or not the prescriber's instructions regarding generic substitution were followed. **ProviderOne Companion Guide Rules D.0:** *Enter:* *0 = No product selection* *1 = Physician's request* *2 = Substitution allowed- patient requested product dispensed* *3 = Substitution allowed- pharmacist selected product dispensed* *4 = Substitution allowed- generic drug not in stock* *5 = Substitution allowed- brand drug dispensed as generic* *6 = Override* *7 = Substitution not allowed- brand drug mandated by law* *8 = Substitution allowed- generic drug not available in marketplace* *9 = Other*					
414-DE	Date Prescription Written	8	9(8)	N	O	Must use
	Definition: Date prescription was written. **ProviderOne Companion Guide Rules D.0:**					

	*Enter date in CCYYMMDD format e.g. 20090401 for April 1st **2009***						
354-NX	Submission Clarification Code Count					O	Used
354-NX	Submission Clarification Code Count	1	9(1)	N		M	Must use
	Definition: Count of the 'Submission Clarification Code' (420-DK) occurrences. **ProviderOne Companion Guide Rules D.0:** *Count of the 'Submission Clarification Code' occurrences required when 'Submission Clarification Code is used'*						
354-NX	Submission Clarification Code Count				9	O	Used
420-DK	Submission Clarification Code	2	9(2)	N		O	Used
	Definition: Code indicating that the pharmacist is clarifying the submission. **ProviderOne Companion Guide Rules D.0:** *As per External Code List under D.0 Maximum 3 occurrence allowed.*						
460-ET	Quantity Prescribed	10	9(7)v999	N		O	Used
	Definition: Amount expressed in metric decimal units. **ProviderOne Companion Guide Rules D.0:** *Format=9999999.999*						
308-C8	Other Coverage Code	2	9(2)	N		O	Used
	Definition: Code indicating whether or not the patient has other insurance coverage. **ProviderOne Companion Guide Rules D.0:** *2 = Other coverage exists-payment collected* *3 = Other coverage billed- claim not covered* *4 = Other coverage exists - payment not collected*						
461-EU	Prior Authorization Type Code	2	9(2)	N		O	Used
	Definition: Code clarifying the 'Prior Authorization Number Submitted' (462-EV) or benefit/plan exemption. **ProviderOne Companion Guide Rules D.0:** *REQUEST CLAIM SEGMENT*						
462-EV	Prior Authorization Number Submitted	11	9(11)	N		O	Used
	Definition: Number submitted by the provider to identify the prior authorization. **ProviderOne Companion Guide Rules D.0:** *Authorization or Expedited Authorization Number*						
995-E2	Route of Administration	11	x(11)	A/N		O	Used
	Definition: This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture. **ProviderOne Companion Guide Rules D.0:** *Use NCPDP applicable codes*						
996-G1	Compound Type	2	X(2)	A/N		O	Used
	Definition: Clarifies the type of compound. **ProviderOne Companion Guide Rules D.0:** *As per External Code List under D.0*						

03 Prescriber

POS: 7
Optional
Transaction: B1

RP#: 1
Fields: 13

User Option (Usage): Used

Field ID	Name	Len	Format	DT	Rep	Req	Usage
111-AM	Segment Identification	2	x(2)	A/N		M	Must use
	Definition: Identifies the segment in the request and/or response.						
	ProviderOne Companion Guide Rules D.0: *Use '03'*						
466-EZ	Prescriber ID Qualifier					O	Used
466-EZ	Prescriber ID Qualifier	2	x(2)	A/N		M	Must use
	Definition: Code qualifying the 'Prescriber ID' (411-DB).						
	ProviderOne Companion Guide Rules D.0: *Please use: 01 - NPI 12 - DEA Number*						
411-DB	Prescriber ID	15	x(15)	A/N		M	Must use
	Definition: ID assigned to the prescriber.						
	ProviderOne Companion Guide Rules D.0: *Enter the NPI or DEA Number of the Prescribing Physician*						

05 COB/Other Payments

POS: 8
Optional
Transaction: B1

RP#: 1
Fields: 18

User Option (Usage): Used

Field ID	Name	Len	Format	DT	Rep	Req	Usage
111-AM	Segment Identification	2	x(2)	A/N		M	Must use
	Definition: Identifies the segment in the request and/or response.						
	ProviderOne Companion Guide Rules D.0: *Use '05'*						
337-4C	Coordination of Benefits/Other Payments Count					M	Must use
337-4C	Coordination of Benefits/Other Payments Count	1	9(1)	N		M	Must use
	Definition: Count of other payment occurrences.						
	ProviderOne Companion Guide Rules D.0: *Comments: Fields included in the set/logical grouping are: 'Other Payer Coverage Type' (338-5C) 'Other Payer ID Qualifier' (339-6C) 'Other Payer ID' (340-7C) 'Other Payer Date' (443-E8) 'Other Payer Amount Paid' (431-DV) 'Other Payer-Patient Responsibility Amount Qualifier' (351-NP) 'Other Payer-Patient Responsibility Amount' (352-NQ or if rejected 'Other Payer Reject Count' (471-5E) and 'Other Payer Reject Code' (472-6E)*						
337-4C	Coordination of Benefits/Other Payments Count				9	M	Must use
338-5C	Other Payer Coverage Type	2	x(2)	A/N		M	Must use
	Definition: Code identifying the type of 'Other Payer ID' (340-7C).						
	ProviderOne Companion Guide Rules D.0:						

	01 = Primary						
339-6C	Other Payer ID Qualifier					O	Used
339-6C	Other Payer ID Qualifier	2	x(2)	A/N		M	Must use
	Definition: Code qualifying the 'Other Payer ID' (340-7C). **ProviderOne Companion Guide Rules D.0:** *Use '99'*						
340-7C	Other Payer ID	10	x(10)	A/N		M	Must use
	Definition: ID assigned to the payer. **ProviderOne Companion Guide Rules D.0:** *Enter Payer Name*						
443-E8	Other Payer Date	8	9(8)	N		O	Used
	Definition: Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits. **ProviderOne Companion Guide Rules D.0:** *Enter date in CCYYMMDD format e.g. 20090401 for April 1st* ***2009***						
341-HB	Other Payer Amount Paid Count					O	Used
341-HB	Other Payer Amount Paid Count	1	9(1)	N		M	Must use
	Definition: Count of the payer amount paid occurrences.						
341-HB	Other Payer Amount Paid Count				9	O	Used
342-HC	Other Payer Amount Paid Qualifier					O	Used
342-HC	Other Payer Amount Paid Qualifier	2	x(2)	A/N		M	Must use
	Definition: Code qualifying the 'Other Payer Amount Paid' (431-DV). **ProviderOne Companion Guide Rules D.0:** *Use:* *'07' - Drug benefit*						
431-DV	Other Payer Amount Paid	8	s9(6)v99	D		M	Must use
	Definition: Amount of any payment known by the pharmacy from other sources. **ProviderOne Companion Guide Rules D.0:** *Enter the amount that the other payer paid as '$$$$$$cc'.*						
353-NR	Other Payer-Patient Responsibility Amount Count					O	Used
353-NR	Other Payer-Patient Responsibility Amount Count	2	9(2)	N		M	Must use
	Definition: Count of "Other Payer-Patient Responsibility Amount" (352-NQ) and "Other Payer-Patient Responsibility Amount Qualifier" (351-NP) occurrences. **ProviderOne Companion Guide Rules D.0:** *U&C amount submitted on the claim by the pharmacy to the MCOs PBM.* *Required when Other Payer-Patient Responsibility Amount* *Qualifier (351-NP) is use.*						
353-NR	Other Payer-Patient Responsibility Amount Count				99	O	Used
351-NP	Other Payer-Patient Responsibility Amount Qualifier					O	Used
351-NP	Other Payer-Patient Responsibility Amount Qualifier	2	X(2)	A/N		M	Must use
	Definition: Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)". **ProviderOne Companion Guide Rules D.0:** *Required when Other Payer-Patient Responsibility amount Count (353-NR) is use.*						
352-NQ	Other Payer-Patient Responsibility Amount	10	s9(8)v99	D		M	Must use
	Definition: The patient's cost share from a previous payer. **ProviderOne Companion Guide Rules D.0:** *Enter the amount Other Payer-Patient* Responsibility as '$$$$$$cc'.						

08 DUR/PPS

POS: 10
Optional
Transaction: B1

RP#: 1
Fields: 8

User Option (Usage): Used

Field ID	Name	Len	Format	DT	Rep	Req	Usage
111-AM	Segment Identification	2	x(2)	A/N		M	Must use
	Definition: Identifies the segment in the request and/or response. **ProviderOne Companion Guide Rules D.0:** *Use '08'*						
473-7E	DUR/PPS Code Counter				9	O	Used
473-7E	DUR/PPS Code Counter	1	9(1)	N		M	Must use
	Definition: Counter number for each DUR/PPS set/logical grouping. **ProviderOne Companion Guide Rules D.0:** *Comments: Fields included in the set/logical grouping are: 'Reason of Service Code' (439-E4) 'Professional Service Code' (440-E5) 'Result of Service Code' (441-E6) 'DUR/PPS Level of Effort' (474-8E) 'DUR Co-Agent ID Qualifier' (475-9E) 'DUR Co-Agent ID' (476-H6)*						
439-E4	Reason For Service Code	2	x(2)	A/N		O	Used
	Definition: Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service. **ProviderOne Companion Guide Rules D.0:** *Required if segment used*						
440-E5	Professional Service Code	2	x(2)	A/N		O	Used
	Definition: Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered. **ProviderOne Companion Guide Rules D.0:** *Required if segment used*						
441-E6	Result of Service Code	2	x(2)	A/N		O	Used
	Definition: Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service. **ProviderOne Companion Guide Rules D.0:** *Required if segment used*						

11 Pricing

POS: 11
Mandatory
Transaction: B1

RP#: 1
Fields: 17

User Option (Usage): Must use

Field ID	Name	Len	Format	DT	Rep	Req	Usage
111-AM	Segment Identification	2	x(2)	A/N		M	Must use
	Definition: Identifies the segment in the request and/or response. **ProviderOne Companion Guide Rules D.0:** *Use '11'*						

409-D9	Ingredient Cost Submitted	8	s9(6)v99	D	O	Must use

Definition: Submitted product component cost of the dispensed prescription. This amount is included in the 'Gross Amount Due' (430-DU).

ProviderOne Companion Guide Rules D.0: *Format=$$$$$$cc*
Comments: This field can be further defined by using the Basis of Cost Determination Field 423-DN.
Examples: If the ingredient cost submitted is $65.00,this field would reflect: 650{.

438-E3	Incentive Amount Submitted	8	s9(6)v99	D	O	Used

Definition: Amount represents a fee that is submitted by the pharmacy for contractually agreed upon services. This amount is included in the 'Gross Amount Due' (430-DU).

ProviderOne Companion Guide Rules D.0: *Format=$$$$$$cc*
Examples: If the incentive amount submitted is $4.50, this field would reflect: 45{.

478-H7	Other Amount Claimed Submitted Count				O	Used
478-H7	Other Amount Claimed Submitted Count	1	9(1)	N	M	Must use

Definition: Count of other amount claimed submitted occurrences.

ProviderOne Companion Guide Rules D.0:
Not Required - Captured if transmitted.

478-H7	Other Amount Claimed Submitted Count			9	O	Used
479-H8	Other Amount Claimed Submitted Qualifier				O	Used
479-H8	Other Amount Claimed Submitted Qualifier	2	x(2)	A/N	M	Must use

Definition: Code identifying the additional incurred cost claimed in 'Other Amount Claimed Submitted' (480-H9).

480-H9	Other Amount Claimed Submitted	8	s9(6)v99	D	M	Must use

Definition: Amount representing the additional incurred costs for a dispensed prescription or service.

ProviderOne Companion Guide Rules D.0: *Format=s$$$$$$cc*
Comments: Qualified by 'Other Amount Claimed Submitted Qualifier' (479-H8). Examples: If the other amount claimed submitted is $12.55, this field would reflect: 125E.

426-DQ	Usual and Customary Charge	8	s9(6)v99	D	O	Used

Definition: Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.

ProviderOne Companion Guide Rules D.0:
U&C submitted on the claim by the pharmacy to the MCO's PBM.
Usual and Customary amount as '$$$$$$cc'.

430-DU	Gross Amount Due	8	s9(6)v99	D	O	Must use

Definition: Total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (409-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (480-H9). For service claim request, field represents a sum of 'Professional Services Fee Submitted' (477-BE), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Other Amount Claimed' (480-H9).

ProviderOne Companion Guide Rules D.0:
Billed amount entered as '$$$$$$cc'.

10 Compound

POS: 13
Optional
Transaction: B1

RP#: 1

Fields: 11

User Option (Usage): Used

Field ID	Name	Len	Format	DT	Rep	Req	Usage
111-AM	Segment Identification	2	x(2)	A/N		M	Must use

Definition: Identifies the segment in the request and/or response.

	ProviderOne Companion Guide Rules D.0: *Use '10'*						
450-EF	Compound Dosage Form Description Code	2	x(2)	A/N		M	Must use
	Definition: Dosage form of the complete compound mixture.						
	ProviderOne Companion Guide Rules D.0: *Use NCPDP applicable Compound Dosage Form Description Code*						
451-EG	Compound Dispensing Unit Form Indicator	1	9(1)	N		M	Must use
	Definition: NCPDP standard product billing codes.						
	ProviderOne Companion Guide Rules D.0: *Use NCPDP applicable Indicators*						
447-EC	Compound Ingredient Component Count					M	Must use
447-EC	Compound Ingredient Component Count	2	9(2)	N		M	Must use
	Definition: Count of compound product IDs (both active and inactive) in the compound mixture submitted.						
	ProviderOne Companion Guide Rules D.0: *Count of Product ID in the Compound must match the number of ingredients reported*						
447-EC	Compound Ingredient Component Count				99	M	Must use
488-RE	Compound Product ID Qualifier					M	Must use
488-RE	Compound Product ID Qualifier	2	x(2)	A/N		M	Must use
	Definition: Code qualifying the type of product dispensed.						
	ProviderOne Companion Guide Rules D.0: *Please use:* *03 = National Drug Code*						
489-TE	Compound Product ID	19	x(19)	A/N		M	Must use
	Definition: Product identification of an ingredient used in a compound.						
	ProviderOne Companion Guide Rules D.0: *Enter 11 Digit NDC Number from Medi-Span*						
448-ED	Compound Ingredient Quantity	10	9(7)v999	N		M	Must use
	Definition: Amount expressed in metric decimal units of the product included in the compound mixture.						
	ProviderOne Companion Guide Rules D.0: *Enter the Ingredient quantity '9999999999'*						
449-EE	Compound Ingredient Drug Cost	8	s9(6)v99	D		O	Used
	Definition: Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).						
	ProviderOne Companion Guide Rules D.0: *Enter cost of ingredient '$$$$$$cc'*						
362-2G	Compound Ingredient Modifier Code Count					O	Used
362-2G	Compound Ingredient Modifier Code Count	2	9(2)	N		M	Must use
	Definition: Code indicating the number of Compound Ingredient Modifier Code (363-2H)						
	ProviderOne Companion Guide Rules D.0: *Code indicating the number of Compound Ingredient Modifier Code*						
362-2G	Compound Ingredient Modifier Code Count				99	O	Used
363-2H	Compound Ingredient Modifier Code	2	X(2)	A/N		O	Used
	Definition: Identifies special circumstances related to the dispensing/payment of the product as identified in the Compound Product ID (498-TE).						
	ProviderOne Companion Guide Rules D.0: *CMS code set of HCPCS modifiers - Maximum Occurrence allowed 10*						

Clinical

13

POS: 14
Optional
Transaction: B1

RP#: 1

Fields: 10

User Option (Usage): Used

Field ID	Name	Len	Format	DT	Rep	Req	Usage
111-AM	Segment Identification	2	x(2)	A/N		M	Must use
	Definition: Identifies the segment in the request and/or response.						
	ProviderOne Companion Guide Rules D.0: *Use '13'*						
491-VE	Diagnosis Code Count					O	Used
491-VE	Diagnosis Code Count	1	9(1)	N		M	Must use
	Definition: Count of diagnosis occurrences.						
	ProviderOne Companion Guide Rules D.0: *Comments: Fields included in the set/logical grouping are: 'Diagnosis Code Qualifier' (492-WE) 'Diagnosis Code' (424-DO)*						
491-VE	Diagnosis Code Count				9	O	Used
492-WE	Diagnosis Code Qualifier					O	Used
492-WE	Diagnosis Code Qualifier	2	x(2)	A/N		M	Must use
	Definition: Code qualifying the 'Diagnosis Code' (424-DO).						
424-DO	Diagnosis Code	15	x(15)	A/N		M	Must use
	Definition: Code identifying the diagnosis of the patient.						
	ProviderOne Companion Guide Rules D.0: *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.*						

23 Response Pricing

POS: 18
Optional
Transaction: B1

RP#: 1

Fields: 11

User Option (Usage): Must Use

Field ID	Name	Len	Format	DT	Rep	Req	Usage
111-AM	Segment Identification	2	x(2)	A/N		M	Must use
	Definition: Identifies the segment in the request and/or response.						
	ProviderOne Companion Guide Rules D.0: *Use '23'*						
501-F1	Header Response Status	1	x(1)	A/N		M	Must use
	Definition: Code indicating the status of the transmission.						
	ProviderOne Companion Guide Rules D.0: *Code indicating the status of the transmission.* *A = Accepted - Code indicating the receipt and approval of the transmission.* *R = Rejected - Code indicating the rejection or refusal to accept the transmission.*						
833-5P	Pharmacy Name	70	x(70)	A/N		M	Must use
	Definition: Name of the Pharmacy that the claim was submitted with. There is a possibility that this pharmacy is not present in ProviderOne						
	ProviderOne Companion Guide Rules D.0: *Name of the Pharmacy that submitted the claim. There is a possibility that this pharmacy is not present in ProviderOne*						
409-Z8	Allowed Ingredient Amount	8	s9(6)v99	N		M	Must use
	Definition: The Allowed Ingredient Amount cost calculated by the MCO						
	ProviderOne Companion Guide Rules D.0: *The Allowed Ingredient Amount cost calculated by the MCO or PBM, Enter as Overpunch Pricing.* Example: $15.00 This field would reflect: 150{ Note: *If 501-F1 value is R (Denied Pharmacy Encounter by MCO) then value of 409-Z8 should be zero (0000000{) dollars.*						
509-F9	Total Amount Paid	8	s9(6)v99	D		O	Must use
	Definition: Total amount to be paid by the claims processor (i.e. pharmacy receivable). Represents a sum of 'Ingredient Cost Paid' (506-F6),'Dispensing Fee Paid' (507-F7),'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive Amount Paid' (521-FL),'Professional Service Fee Paid' (562-J1), 'Other Amount Paid' (565-J4),less 'Patient Pay Amount' (505-F5) and 'Other Payer Amount Recognized' (566-J5).						
	ProviderOne Companion Guide Rules D.0: *Comments: Format=$$$$$$cc Examples: Ingredient Cost Paid (506-F6)=$20.00+ Dispensing Fee Paid (507-F7)=2.00+ Flat Sales Tax Amount Paid (558-AW)=1.00+ Percentage Sales Tax Amount Paid (559-AX)=.00+ Incentive Amount Paid (521-FL)=00+ Other Amount Paid (565-J4)=.00+ Professional Service Fee Paid (562-J1)=.00-Patient Pay Amount (505-F5)=5.00- Other Payer Amount Recognized (566-J5)=3.00 = Total Amount Paid (509-F9) =$15.00 This field would reflect: 150{* *Note: If 501-F1 value is R (Denied Pharmacy Encounter by MCO) then value of 509-F9 should be zero (0000000{) dollars.*						
399-Z3	Record Status Code	1	x(1)	A/N		O	Used
	Definition: Identifies the transaction status as assigned by the processor.						
	ProviderOne Companion Guide Rules D.0: *Identifies the transaction status as assigned by the processor.* *1 - Paid* *2 - Rejected*						

	3 - Reversed *4 - Adjusted* *5 - Captured* *6 - Reverse*					
203-Z4	Adjudication Time	6	x(6)	A/N	O	Used
	Definition: Time the claim or adjustment is processed. Format=HHMMSS					
	ProviderOne Companion Guide Rules D.0: *Time the claim or adjustment is processed.* *Format=HHMMSS*					
578-Z5	Adjudication Date	8	x(6)	N	O	Used
	Definition: Date the claim or adjustment is processed. Format=CCYYMMDD					
	ProviderOne Companion Guide Rules D.0: *Date the claim or adjustment is processed.* *Format=CCYYMMDD*					
510-FA	Reject Count				O	Used
510-FA	Reject Count	2	9(2)	N	M	Must use
	Definition: Count of 'Reject Code' (511-FB) occurrences.					
	ProviderOne Companion Guide Rules D.0: *Count of Reject Code (511-FB) occurrences.* *Note: If 501-F1 value is R (Denied Pharmacy Encounter by MCO) then 510-FA Reject Count is required.*					
510-FA	Reject Count			5	O	Used
511-FB	Reject Code	3	x(3)	A/N	O	Used
	Definition: Code indicating the error encountered.					
	ProviderOne Companion Guide Rules D.0: *The MCO reject codes. This code indicates the error encountered. - Occurs up to 5 times* *Note: If 501-F1 value is R (Denied Pharmacy Encounter by MCO) then 511-FB Reject Code is required.*					
257-Z9	Formulary Status	1	x(1)	A/N	O	Used
	ProviderOne Companion Guide Rules D.0: *Please Use* *I - Non Preferred* *P - Preferred*					