

GENERAL INFORMATION

Claims Submission: - Point of Sale –
Switch through RelayHealth, Emdeon or eRx Network using NCPDP versions 5.1.

Corporate Chain Headquarters: You must reply with the **input codes** your pharmacies will be utilizing for this plan via fax or e-mail. This will assist our Help Desk personnel in responding to store personnel should rejected claims occur.

Emergency Preparedness: In a ‘declared emergency’, MedImpact will follow the guidelines set by NCPDP in the **NCPDP EMERGENCY PREPAREDNESS INFORMATION Version 1.1** September 2008. See end of Request Transaction section for claim specific details from that document.

National Provider Identifiers (NPI): In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended, all pharmacy providers are required to obtain a National Provider Identifier (NPI) by May 23, 2007 for use when sending electronic standard transactions and code sets as defined by HIPAA.

These specifications cover the minimum required fields per the 5.1 standards as well as the required fields needed for MedImpact claims processing. Even though a segment or field may not be covered in this document, it does not mean the segment or field cannot be sent. All records, segments, and fields that are allowed for 5.1 will be accepted, but only those segments and fields pertinent to claims processing will be utilized in the MedImpact claims system. However, please be cognizant of the size of the transmission and possible problems with processing time on large batch transmissions containing elements that will be ignored by MedImpact. Please refer to the appropriate NCPDP Implementation Guide for further information on the various segments and fields allowed.

TRANSACTIONS SUPPORTED by MedImpact Claims Processing	Transaction Code	Transaction Name
	B1	Billing
	B2	Reversal

***** NCPDP v5.1 REQUEST TRANSACTION *****

BILLING REQUEST:

The following summary lists the segments and fields available in a Billing Transaction. The Transaction Header Segment is mandatory. Fields designed as “Mandatory” (M) are in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1 and are the only fields designated mandatory. Fields designated as “Required” (R) will always be sent. Fields designated as “Required When” (RW) will be sent under circumstances explained in the Comment column. Defined field values are provided when field is Mandatory or Required within a segment used by MedImpact claims processing.

Transaction Header Segment: Mandatory in all cases

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
1Ø1-A1	BIN Number	ØØ3585	M	
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B1 = Billing	M	
1Ø4-A4	Processor Control Number	Definition: ➤ Positions 1-5: Carrier ID, ALPHA/NUMERIC REQUIRED ➤ Positions 6-10: blank.	M	Use value printed on card or as communicated by MedImpact.

109-A9	Transaction Count	1=One Occurrence 2=Two Occurrences 3=Three Occurrences 4=Four Occurrences	M	Only 1 transaction is permitted for Medicare Part D. If Compound Segment is submitted, only 1 transaction is allowed.
202-B2	Service Provider ID Qualifier	01=National Provider Identifier (NPI)	M	Other values will be denied.
201-B1	Service Provider ID	< NPI # >	M	NOTE: NPI# must be registered with NCPDP organization
401-D1	Date of Service	Format = CCYYMMDD	M	<Date Filled>
110-AK	Software Vendor/Certification ID		M	Does not affect claim adjudication.

Insurance Segment: Mandatory

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	04	M	Insurance Segment
302-C2	Cardholder ID	<Cardholder ID Number/Client ID Number > <ALPHA/NUMERIC>	M	Use value printed on card or as communicated by MedImpact.
301-C1	Group ID		RW	Required when needed by plan for proper adjudication. Use value printed on card or as communicated by MedImpact.
303-C3	Person Code		RW	Required when needed by plan for proper adjudication. Use value printed on card or as communicated by MedImpact.
524-FO	Plan ID	<Plan ID Number >	RW	Required when needed by plan for proper adjudication.
309-C9	Eligibility Clarification Code	0 Not Specified 1 No Override 2 Override 3 Full Time Student 4 Disabled Dependent 5 Dependent Parent 6 Significant Other	RW	Required based on plan.

306-C6	Patient Relationship Code	∅ = Not specified 1 = Cardholder 2 = Spouse 3 = Child 4 = Other	R	
336-8C	Facility ID		RW	Required based on plan.

Patient Segment: Optional

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	∅1	M	Patient Segment
304-C4	Date of Birth	Format = CCYYMMDD	R	Patient's Date of Birth
305-C5	Patient Gender Code	∅ = Not Specified 1 = Male 2 = Female	R	Patient's Gender
310-CA	Patient First Name		R	
311-CB	Patient Last Name		R	
307-C7	Patient Location	∅ = Not specified 1 = Home 2 = Inter-Care 3 = Nursing Home 4 = Long Term/Extended Care 5 = Rest Home 6 = Boarding Home 7 = Skilled Care Facility 8 = Sub-Acute Care Facility 9 = Acute Care Facility 10 = Outpatient 11 = Hospice	RW	Medicare Part D: Required for LTC processing. Required when needed by plan for proper adjudication.

The following fields are only required for 'Emergency Preparedness'

322-CM	Patient Street Address			See EMERGENCY PREPAREDNESS section for use in a 'declared' emergency
323-CN	Patient City Address			
324-CO	Patient State/Province Address			
325-CP	Patient Zip/Postal Zone			

Claim Segment: Mandatory *MedImpact does not support partial fill transactions at this time. Therefore, fields 343-HD, 344-HF, and 345-HG are not validated or used for claims processing.*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1 = RX billing	M	Medicare Part D Vaccine plus Administration Fee; use value 1. Administration Fee only Vaccine claims must be billed manually. See NCPDP Version_5_ questions for specifics on vaccine billing.
4Ø2-D2	Prescription/Service Reference Number	<Pharmacy Rx #>	M	
436-E1	Product/Service ID Qualifier	Ø3 – National Drug Code (NDC)	M	
4Ø7-D7	Product/Service ID	<NDC # (Drug Code)>	M	
414-DE	Date Prescription Written	Format = CCYYMMDD	R	
4Ø3-D3	Fill Number	Ø = Original dispensing 1 to 99 = Refill Number	R	
442-E7	Quantity Dispensed	Format = 999999.999	R	
4Ø5-D5	Days Supply		R	
4Ø6-D6	Compound Code	1 = Not a Compound 2 = Compound	R	See Plan Profile Sheet for Compound claim requirements
4Ø8-D8	Dispense As Written (DAW/Product Selection Code)	Ø = No DAW 1 = Physician DAW 2 = Patient DAW 3 = Pharmacy DAW 4 = No Generic Available 5 = Brand dispensed as Generic 6 = Override 7 = Law mandates Brand Drug 8 – Sub Allowed – Generic Unavailable 9 = Other	RW	Required for all DAW edits and restrictions.
415-DF	Number of Refills Authorized		RW	Required when needed by plan for proper adjudication.
42Ø-DK	Submission Clarification Code	Ø = Not Specified 1 = No Override 2 = Other Override 3 = Vacation Supply 4 = Lost Prescription 5 = Therapy Change 6 = Starter Dose 7 = Medically Necessary	RW	Required when needed to clarify the submission.

		8 = Process Compound for Approved Ingredients 9 = Encounters 99 = Other		
308-C8	Other Coverage Code	1= No other coverage identified 2= Other coverage exists- payment collected 3= Other coverage exists- this claim not covered 4= Other coverage exists- payment not collected 5= Managed care plan denial. 6= Other coverage denied - not a participating provider. 7= Other coverage exists- not in effect at time of service. 8= Claim is billing for copay.	RW	Required for non-primary claim submissions. See Plan Profile sheet for COB requirements.
419-DJ	Prescription Origin Code	Ø = Not Specified 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile	RW	As of Jan 1, 2010, Rx Origin Code is required for all NEW prescriptions (fill # 0). The value of zero will be rejected for NEW Rxs.
418-DI	Level of Service	Ø = Not Specified 1 = Patient Consultation 2 = Home Delivery 3 = Emergency 4 = 24 Hour Service 5 = Patient Consultation Regarding Generic Product Selection 6 = In-Home Service	RW	Required when needed by plan for proper adjudication.
429-DT	Unit Dose Indicator	Ø - Not Specified 1 - Not Unit Dose 2 - Manufacturer Unit Dose 3 - Pharmacy Unit Dose	RW	Required when needed by plan for proper adjudication.
461-EU	Prior Authorization Type Code	Ø = Not Specified 1 = Prior Authorization 2 = Medical Certification 3 = EPSDT (Early Periodic Screening Diagnosis Treatment) 4 = Exemption from Copay 5 = Exemption from RX 6 = Family Plan. Indic. 7 = AFDC (Aid to Families with Dependent Children) 8 = Payer Defined Exemption	RW	"4" must be used by LTC providers requesting refunds for waived co-pays for eligible Low-Income Cost-Sharing Subsidy Level IV beneficiaries
462-EV	Prior Authorization Number Submitted		RW	Required when needed by plan for proper adjudication. See EMERGENCY PREPAREDNESS section for use in a 'declared' emergency

Prescriber Segment: Required

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	Ø3	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	01=National Provider Identifier (NPI) 12=Drug Enforcement Administration (DEA) 08 - State License	R	The NPI is the expected identifier. If an NPI is not available, the DEA or State License number can be used as a 'legacy id'. See Plan Profile Sheet for allowed legacy id.
411-DB	Prescriber ID	<ID #>	R	See EMERGENCY PREPAREDNESS section for use in a 'declared' emergency

COB/Other Payments Segment: *COB processing logic is determined by plan. Required data elements and values accepted for COB processing.*

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	Ø5	M	COB/Other Payments Segment
337-4C	COB Count		M	Number of payers submitted in the COB segment. Deny if the count does not match the number of payers submitted.
338-5C	Other Coverage Type	Ø1 = Primary Ø2 = Secondary Ø3 = Tertiary	M	
339-6C	Other Payer ID Qualifier	Ø1 = National Payer ID Ø2 = Health Industry Number (HIN) Ø3 = Bank Information Number (BIN) Ø4 = Nation Association of Insurance Commissioners (NAIC)	RW	Submit Ø3 for BIN number unless indicated otherwise on plan profile sheet
340-7C	Other Payer ID		RW	Must be present
443-E8	Other Payer Date		RW	Must be present with valid date.
341-HB	Other Payer Paid Count		RW	Required when prior payer returned a PAID response to a claim. Must match the number of HC/DV sets.

342-HC	Other Payer Amount Qualifier	Ø1 = Delivery Ø2 = Shipping Ø3 = Postage Ø4 = Administrative Ø5 = Incentive Ø6 = Cognitive Service Ø7 = Drug Benefit Ø8 = Sum of All Reimbursement	RW	Qualifier of Ø8 should only be used when indicating the total reimbursement from the other payer and NOT when submitting line item details of reimbursement components. Segments submitted with Qualifier of Ø8 cannot have additional Other Payer Amount Paid fields (431-DV) submitted.
431-DV	Other Payer Amount Paid		RW	If 3Ø8-C8 Other Coverage Code = 4, Other Payer Amount Paid must be present as zero.
471-5E	Other Payer Reject Count		RW	Required when prior payer returned a REJECTED response which provider is unable to correct for that payer. Must reflect the number of reject codes submitted.
472-6E	Other Payer Reject Code		RW	When used, at least one must be present and valued.

DUR/PPS Segment: Optional *MedImpact does not support repeating fields in DUR/PPS segment. If sent, only the first value of any field will be processed.*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø8	M	DUR/PPS Segment
473-7E	Code Counter Field		RW	Required if segment is used.
439-E4	Reason for Service Code		RW	Required when needed by plan for proper adjudication.
440-E5	Professional Service Code		RW	Required when needed by plan for proper adjudication. For Part D Vaccine Administration, value of "MA" required.
441-E6	Result of Service Code		RW	Required when needed by plan for proper adjudication.

Pricing Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	11	M	Pricing Segment

NCPDP version 5.1 Payer Sheet
Rev. 8/2009



409-D9	Ingredient Cost Submitted		RW	Required if used in Gross Amount Due calculation Should be zero or not submitted when 308-C8 Other Coverage Code = 8,
412-DC	Dispensing Fee Submitted		RW	Required if used in Gross Amount Due calculation Should be zero or not submitted when 308-C8 Other Coverage Code = 8,
438-E3	Incentive Fee		RW	For Part D Vaccine Administration, value must be > 0
478-H7	Other Amount Claimed Submitted Count		RW	Count of other amount claimed submitted occurrences. Used when 308-C8 Other Coverage Code = 8
479-H8	Other Amount Claimed Submitted Qualifier	Blank=Not Specified 01=Delivery Cost 02=Shipping Cost 03=Postage Cost 04=Administrative Cost 99=Other	RW	If 308-C8 Other Coverage Code = 8, value should be 99
480-H9	Other Amount Claimed Submitted		RW	If 308-C8 Other Coverage Code = 8, value should be (505-F5) Patient Pay Amount reported by last payer.
433-DX	Patient Paid Amount Submitted		RW	Required when needed by plan for proper adjudication.

481-HA	Flat Sales Tax Amount Submitted		RW	When required by State law and flat tax is applicable to claim
482-GE	Percentage Sales Tax Amount Submitted		RW	When required by State law and percentage tax is applicable to claim.
484-JE	Percentage Sales Tax Basis Submitted	Blank - Not Specified Ø2 - Ingredient Cost - Ø3 - Ingredient Cost + Dispensing Fee	RW	When required by State law
483-HE	Percentage Sales Tax Rate Submitted		RW	When required by State law. Tax Rate will be used on calculated reimbursement to determine applicable tax amount.
430-DU	Gross Amount Due	Format = s\$\$\$\$\$cc	R	Required. Must summarize according to NCPDP formula. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (4Ø9-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' (48Ø-H9).
426-DQ	U&C Charge	Format = s\$\$\$\$\$cc	R	Required

Compound Segment: Optional *MedImpact supports the Compound segment for some plans. See Plan Profile Sheet to determine how compounds should be billed. When the Compound Segment is required, fields are Mandatory or Optional per NCPDP 5.1 guidance.*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	10	M	Compound Segment
45Ø-EF	Compound Dosage Form Description Code	Blank=Not Specified Ø1=Capsule Ø2=Ointment Ø3=Cream Ø4=Suppository Ø5=Powder Ø6=Emulsion Ø7=Liquid 1Ø=Tablet 11=Solution 12=Suspension 13=Lotion 14=Shampoo 15=Elixir 16=Syrup 17=Lozenge 18=Enema	M	Required if segment is used.
451-EG	Compound Dispensing Unit Form Indicator	1=Each 2=Grams 3=Milliliters	M	Required if segment is used.

452-EH	Compound Route Of Administration	Ø=Not Specified 2=Dental 4=Injection 5=Intraperitoneal 6=Irrigation 7=Mouth/Throat 8=Mucous Membrane 9=Nasal 1Ø=Ophthalmic 12=Other/Misc 14=Perfusion 16=Sublingual 18=Transdermal 9=Translingual 2Ø=Urethral 22=Enteral	1=Buccal 3=Inhalation 11=Oral 13=Otic 15=Rectal 17=Topical 21=Vaginal	M	Required if segment is used.
447-EC	Compound Ingredient Component Count			M	Required if segment is used. Max count of 25
488-RE	Compound Product Id Qualifier	Ø3 – National Drug Code (NDC)		M	Required if segment is used.
489-TE	Compound Product Id	<NDC # (Drug Code)>		M	Required if segment is used.
448-ED	Compound Ingredient Quantity			M	Required if segment is used.
449-EE	Compound Ingredient Drug Cost			R	Required if segment is used.
49Ø-UE	Compound Ingredient Basis Of Cost Determination	Blank=Not Specified Ø1=AWP (Avg Wholesale Price) Ø2=Local Wholesaler Ø3=Direct Ø4=EAC (Est. Acquisition Cost) Ø5=Acquisition Ø6=MAC (Max. Allowable Cost) Ø7=Usual & Customary Ø9=Other		R	Required if segment is used.

Prior Authorization Segment: *MedImpact does not support the Prior Authorization segment at this time.*

Clinical Segment: *Optional MedImpact does not support repeating fields in Clinical segment. If sent, only the first value of any field will be processed.*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	13	M	Clinical Segment
491-VE	Diagnosis Code Count	1	RW	Required when Diagnosis Code is sent
492-WE	Diagnosis Code Qualifier	01 – ICD-9	RW	Required when Diagnosis Code is sent
424-DO	Diagnosis Code		RW	Required when needed by plan for proper adjudication.

EMERGENCY PREPAREDNESS:

In the event of a ‘declared emergency’, the following guidelines will be followed:

Patient Segment is for the demographic information from which the patient has been displaced. This may/may not be where the patient is residing during the emergency.

322-CM	Patient Street Address	The street address of patient's home from where they were displaced.
323-CN	Patient City Address	The city of patient's home from where they were displaced.
324-CO	Patient State/Province Address	The state of patient's home from where they were displaced.
325-CP	Patient Zip/Postal Zone	The zip/postal code of patient's home from where they were displaced.

Claim Segment

Prior Authorization Number Submitted (462-EV):

911000000000	Emergency Preparedness (EP) Refill Extension Override. Use value to allow refill beyond refill limit on benefit.
911000000001	Emergency Preparedness (EP) Refill Too Soon Edit Override. Use value when the patient needs medication because of emergency and processor returns a reject.
911000000002	Emergency Preparedness (EP) Prior Authorization Requirement Override
911000000003	Emergency Preparedness (EP) Accumulated Quantity Override
911000000004	Emergency Preparedness (EP) Step Therapy Override
911000000005	Emergency Preparedness (EP). Use value to remove restriction for refill limit, Prior Authorization, Refill Too Soon, Accumulated Quantity and Step Therapy.

Prescriber Segment

411-DB Prescriber Id In a 'declared emergency situation' when the pharmacist prescribes, NPI of the pharmacy may be submitted

***** NCPDP v5.1 RESPONSE TRANSACTION *****

The purpose of this section is to provide further clarity for Providers as to the Response Data they will receive. This document lists the segments available in a Response Transaction. The Transaction Header Segment is mandatory. Fields designed as "Mandatory" (M) are in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1 and are the only fields designated mandatory. Fields designated as "Required" (R) will always be sent. Fields designated as "Required When" (RW) will be sent under circumstances explained in the Comment column.

MedImpact will respond to the pharmacy in the message text fields indicating any other coverage that may apply to Medicare D beneficiaries. Please ensure that pharmacy personnel can read this information so that supplemental claims can be submitted according to the message instructions.

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
102-A2	Version/Release Number	51	M	Same value as in submitted request.
103-A3	Transaction Code	B1=Billing	M	Same value as in submitted request.
109-A9	Transaction Count		M	Same value as in submitted request.
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	<code#>	M	Same value as in submitted request.

201-B1	Service Provider ID	<ID #>	M	Same value as in submitted request.
401-D1	Date of Service		M	Same value as in submitted request.

Response Message Segment: Optional

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	20	M	Response Message Segment
504-F4	Message		RW	<p>When claim is paid, transmission related messaging may be sent for pharmacy review.</p> <p>When claim transmission is rejected, contains text information when needed to further explain transmission response.</p> <p>For Part D Only: ADDINS: <<Order of Coverage for Insurance>>;BN:<<BIN>>;PN:<<PCN>>;GP:<<Group ID No>>;ID:<<Member No>>;PC:<<Person Code>>;PH:<<Payer Phone>></p>

Response Insurance Segment: Not Used

Response Status Segment: Mandatory

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	P = Paid D = Duplicate R = Rejected	M	
526-FQ	Additional Message Information		RW	<p>When claim is paid, additional transaction related messaging may be sent for pharmacy review.</p> <p>When claim transaction is rejected, contains text information when needed to further explain transaction response.</p> <p>For Part D Only: messaging overflowed from the 504-F4 field may be present.</p>

503-F3	Authorization Number		R	Provides the MedImpact "Claim ID"
510-FA	Reject Count		RW	Provided when claim has been rejected. Can contain up to three rejects.
511-FB	Reject Code		RW	Provided when claim has been rejected. Contains the NCPDP Error Code.

Response Claim Segment: Mandatory *MedImpact does not support preferred product fields at this time.*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier		M	Same value as in submitted request.
402-D2	Prescription/Service Reference Number	<Pharmacy Rx #>	M	Same value as in submitted request.

Response Pricing Segment: Mandatory when claim is PAID (P or D Transaction Response Code)

MedImpact shall supply information regarding the member's overall pharmacy benefit in the Accumulated Deductible Amount, Remaining Deductible Amount, and Remaining Benefit Amount fields. MedImpact does not support partial fill processing at this time.

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	23	M	Response Pricing Segment
505-F5	Patient Pay Amount		R	Contains total amount Patient is expected to pay
506-F6	Ingredient Cost Paid		R	Contains Ingredient Cost.
507-F7	Dispensing Fee Paid		R	Contains Fill Fee.
558_AW	Flat Sales Tax Amount Paid		RW	Contains flat tax amount if submitted on claim.
559-AX	Percentage Sales Tax Amount Paid		RW	Contains tax amount paid when Percentage Tax Rate was submitted and tax is required by State law.
521-FL	Incentive Amount Paid		R	In case of Vaccine payment will indicate Administration Fee paid. Will reflect applied incentive fee if applicable.
509-F9	Total Amount Paid		R	Contains Amount to be paid to the pharmacy
522-FM	Basis of Reimbursement Determination	08	R	Contract Pricing
512-FC	Accumulated Deductible Amount		R	When applicable, the amount that has accumulated toward the deductible.
513-FD	Remaining Deductible Amount		R	When applicable, the amount of deductible that remains to be met.

514-FE	Remaining Benefit Amount		R	When applicable, the amount of benefit that has not yet been used.
517-FH	Amount Applied to Periodic Deductible		R	Amount applied toward deductible that is included in Patient Pay Amount.
518-FI	Amount of Copay/Coinsurance		R	Amount of copay or coinsurance that is included in Patient Pay Amount.
519-FJ	Amount Attributed to Product Selection		R	Amount of member cost due to Product Selection that is included in Patient Pay Amount.
520-FK	Amount Exceeding Periodic Benefit Maximum		R	Amount of member cost due to having exceeded the Benefit Maximum that is included in Patient Pay Amount.
523-FN	Amount Attributed to Sales Tax		R	Amount of member cost due to Sales Tax that is included in Patient Pay Amount.

Response DUR/PPS Segment: Optional Required if needed to supply additional information for the utilization conflict or required by plan.

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	24	M	Response DUR/PPS Segment
567-J6	DUR/PPS Response Code Counter		RW	Maximum 9 occurrences supported.
439-E4	Reason for Service Code	See NCPDP Data Dictionary for codes	RW	
528-FS	Clinical Significance Code	Blank=Not Specified 1=Major 2=Moderate 3=Minor	RW	Contains DUR edit severity level.
529-FT	Other Pharmacy Indicator	∅ – Not specified 1 – Your pharmacy 3 – Other pharmacy	RW	Depending on Pharmacy Address.
530-FU	Previous Date of Fill		RW	Contains claim date of conflicting drug.
531-FV	Quantity of Previous Fill		RW	Contains quantity of conflicting drug.
532-FW	Database Indicator	1=First Databank	RW	
544-FY	DUR Free Text Message		RW	Contains DUR description.

REVERSAL REQUEST:

Maximum Number of Transactions Supported per transmission:	One (1)
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	None

The following lists the segments available in a Reversal Transaction. The Transaction Header Segment is mandatory. The Segment Summaries included below list the mandatory data fields. Fields designed as "Mandatory" (M) are in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1 and are the only fields designated mandatory. Fields designated as "Required" (R) will always be sent.

Transaction Header Segment: Mandatory in all cases

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
1Ø1-A1	BIN Number	ØØ3585	M	
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B2=Reversal	M	
1Ø4-A4	Processor Control Number	Definition: ➤ Positions 1-5: Carrier ID, ALPHA/NUMERIC REQUIRED ➤ Positions 6-10: blank.	M	Use value printed on card or as communicated by MedImpact.
1Ø9-A9	Transaction Count	1 = One Occurrence	M	Maximum of 1
2Ø2-B2	Service Provider ID Qualifier	01=National Provider Identifier (NPI)	M	Other values will be denied.
2Ø1-B1	Service Provider ID	< NPI # >	M	NOTE: NPI# must be registered with NCPDP organization
4Ø1-D1	Date of Service	Format = CCYYMMDD	M	<Date Filled>
11Ø-AK	Software Vendor/Certification ID		M	Does not affect claim adjudication.

Insurance Segment: Mandatory

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID	<Cardholder ID Number/Client ID Number> <ALPHA/NUMERIC>	M	Use value printed on card or as communicated by MedImpact.
3Ø1-C1	Group ID		RW	Required if submitted on claim
524-FO	Plan ID		RW	Required if submitted on claim

Claim Segment: Mandatory

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1 = RX billing	M	
4Ø2-D2	Prescription/Service Reference Number	<Pharmacy Rx #>	M	
436-E1	Product/Service ID Qualifier	Ø3 – National Drug Code (NDC)	M	Must contain the Product/Service ID Qualifier (436-E1) value from original Billing.
4Ø7-D7	Product/Service ID	<NDC # (Drug Code)>	M	Must contain the Product/Service ID (4Ø7-D7) value from original Billing.
4Ø3-D3	Fill Number	Ø = Original dispensing 1 to 99 = Refill Number	R	

REVERSAL RESPONSE:

Transaction Header Segment: Mandatory

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
1Ø2-A2	Version/Release Number	51	M	Same value as in submitted request.
1Ø3-A3	Transaction Code	B1=Billing	M	Same value as in submitted request.
1Ø9-A9	Transaction Count		M	Same value as in submitted request.
5Ø1-F1	Header Response Status	A = Accepted	M	
2Ø2-B2	Service Provider ID Qualifier	<code#>	M	Same value as in submitted request.
2Ø1-B1	Service Provider ID	<ID #>	M	Same value as in submitted request.
4Ø1-D1	Date of Service		M	Same value as in submitted request.

Response Message Segment: Optional

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	20	M	Response Message Segment
504-F4	Message		RW	

Response Status Segment: Mandatory

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	A = Approved R = Rejected	M	
526-FQ	Additional Message Information		RW	Additional transaction related messaging may be sent for pharmacy review.
503-F3	Authorization Number		R	Provides the MedImpact "Claim ID" for the reversal.
510-FA	Reject Count		RW	Provided when reversal has been rejected. Can contain up to three rejects.
511-FB	Reject Code		RW	Provided when reversal has been rejected. Contains the NCPDP Error Code.