

# Pharmacy Billing Manual

<b>Pharmacy Requirements and Benefits</b> .....	5
<i>1990 OBRA Rebate Program</i> .....	5
<i>Prior Authorization Request Process</i> .....	5
Medications Requiring a Prior Authorization.....	6
Guidelines Used by the Department for Determining Prior Authorization Criteria.....	6
Generic Mandate.....	7
<i>Dispensing Requirements</i> .....	7
Tamper Resistant Prescription Pads.....	7
Compounded Prescriptions.....	7
Partial Fills and/or Prescription Splitting.....	8
Emergency Three Day Supply.....	8
Lost/Stolen/Damaged/Vacation Prescriptions.....	8
Counseling.....	8
Override Codes.....	8
Co-payment Exclusions.....	8
Reversals.....	9
Retention of Records.....	9
Mail Order.....	9
<i>Restricted Products</i> .....	10
<i>Exclusions</i> .....	10
<i>Fiscal Agent Helpdesk</i> .....	11
<b>Pharmacy Claim Billing Instructions</b> .....	12
<i>Timely Filing Requirements</i> .....	12
Rebilling Denied Claims.....	12
Request for Reconsideration.....	14
Appealing Reconsideration Denials.....	14
<i>Paper Claim Submission Requirements</i> .....	14
Instructions for Completing the Pharmacy Claim Form (PCF).....	14
<i>Electronic Claim Submission Requirements</i> .....	18

**NCPDP VERSION D.0 PAYER SHEET- B1/B3 (Billing & Rebilling)Transactions.....39**

- Transaction Header Segment:.....41
- Insurance Segment: .....42
- Patient Segment: .....42
- Claim Segment: .....43
- Pricing Segment: .....46
- Prescriber Segment:.....46
- COB/Other Payments Segment: .....47
- DUR/PPS Segment: .....51
- Compound Segment: .....51
- Clinical Segment: .....53
- Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) Response .....54**
- Response Transaction Header Segment:.....54
- Response Message Segment:.....55
- Response Insurance Segment: .....55
- Response Status Segment:.....56
- Response Claim Segment:.....57
- Response Pricing Segment:.....57
- Response DUR/PPS Segment:.....58
- Claim Billing/Claim Rebill Rejected/Rejected Response.....60**
- Response Transaction Header Segment :.....60
- Response Message Segment:.....60
- Response Insurance Segment:.....61
- Response Status Segment:.....61
- Response Claim Segment.....62
- Response DUR/PPS Segment:.....63
- Response Transaction Header Segment:.....63
- Response Message Segment:.....63
- Response Status Segment:.....66
- DUR Codes.....66**
- Reason for Service Codes (439-E4): DUR Conflict Codes.....66
- Professional Service Codes (440-E5) .....66

Result of Service Codes (441-E6).....66

**NCPDP VERSION D.0 PAYER SHEET – B2(Reversal) Transactions.....67**

Transaction Header Segment:.....68

Insurance Segment:.....68

Claim Segment:.....69

COB/Other Payments Segment: .....70

**History for Pharmacy Billing Manual.....71**

# Pharmacy Requirements and Benefits

---

This manual explains many Department of Health Care Policy and Financing's (Department) policies regarding billing, provider responsibilities and Colorado Medical Assistance Program benefits. Providers should also consult the [Code of Colorado Regulations](#) (10 C.C.R. 2505-10 Section 8.100) for further guidance regarding benefits and billing requirements.

## 1990 OBRA Rebate Program

Federal regulation requires that drug manufacturers sign a national rebate agreement with the Centers for Medicaid and Medicare Services (CMS) to participate in the state Medical Assistance Program. Drugs produced by companies that have signed a rebate agreement (participating companies) are generally a Medical Assistance Program benefit but may be subject to restrictions. In addition, some products are excluded from coverage and are listed on page 8. The Medical Assistance Program does not provide reimbursement for products by manufacturers that have not signed a rebate agreement unless the Department has made a determination that the availability of the drug is essential, such drug has been given 1-A rating by the Food and Drug Administration (FDA), and prior authorized.

## Prior Authorization Request (PAR) Process

Drugs that are considered regular Medical Assistance Program benefits do not require prior authorization. Certain restricted drugs require prior authorization before they are covered as a benefit of the Medical Assistance Program.

**The procedure to request a prior authorization and the medications that require a prior authorization are outlined in [APPENDIX P](#) located in the [Pharmacy](#) section of the Department's Web site at [colorado.gov/hcpf](http://colorado.gov/hcpf).**

Prior authorization requests are reviewed by the Department or the Department's fiscal agent. All pharmacy PARs must be telephoned and/or faxed by the prescribing physician or physician's agent to the Prescription Drug Card System PDCS Pharmacy Support numbers identified in Appendix P. Notification of the prior authorization approval or denial is sent to each of the following parties:

- THE REQUESTING PHYSICIAN
- THE PROPOSED RENDERING PROVIDER (IF IDENTIFIED ON THE PAR)
- THE MEDICAL ASSISTANCE PROGRAM CLIENT

In addition to stating whether the PAR has been approved or denied, the notification letter identifies the client's appeal rights. Only clients have the right to appeal a prior authorization request decision.

If additional information is requested in order to process the PAR, the physician should provide the information by phone or fax.

**Approval of a PAR does not guarantee Medical Assistance Program payment.** Prior authorization only assures that the approved service is medically necessary and considered to be a benefit of the Medical Assistance Program. All claims, including those for prior authorized services, must meet claim submission requirements before payment can be made. Some claim submission requirements include: timely filing, eligibility requirements, pursuit of third party resources and required attachments included. **A PAR approval does not override any of the claim submission requirements.**

## Medications Requiring a Prior Authorization

- CERTAIN RESTRICTED DRUGS
- NON-PREFERRED AGENTS SUBJECT TO THE PREFERRED DRUG LIST (PDL)
- OVER-THE-COUNTER DRUGS THAT ARE NOT A REGULAR MEDICAL ASSISTANCE PROGRAM BENEFIT
- SOME HOME INTRAVENOUS (IV) SOLUTIONS
- TOTAL PARENTERAL NUTRITION (TPN) THERAPY AND DRUGS

## Guidelines Used by the Department for Determining Prior Authorization Criteria

In determining what drugs should be subject to prior authorization, the Department applies the following criteria:

- SIGNIFICANCE OF IMPACT ON THE HEALTH OF THE MEDICAL ASSISTANCE PROGRAM POPULATION OR COSTS TO THE MEDICAL ASSISTANCE PROGRAM
- REQUIRED MONITORING OF PRESCRIBING PROTOCOLS TO PROTECT BOTH THE LONG-TERM EFFICACY OF THE DRUG AND THE PUBLIC HEALTH
- POTENTIAL FOR, OR A HISTORY OF, DRUG DIVERSION AND OTHER ILLEGAL UTILIZATION
- APPEARANCE OF THE MEDICAL ASSISTANCE PROGRAM USAGE IN AMOUNTS INCONSISTENT WITH NON-MEDICAL ASSISTANCE PROGRAM USAGE PATTERNS, AFTER ADJUSTING FOR POPULATION CHARACTERISTICS
- CLINICAL EFFICACY COMPARED TO OTHER DRUGS IN THAT CLASS OF MEDICATIONS
- AVAILABILITY OF MORE COST EFFECTIVE COMPARABLE ALTERNATIVES
- PROCEDURES WHERE INAPPROPRIATE UTILIZATION HAS BEEN REPORTED IN MEDICAL LITERATURE
- PERFORMING AUDITING SERVICES WITH CONSTANT REVIEW ON DRUG UTILIZATION

## Generic Mandate

Most brand-name drugs with a generic therapeutic equivalent are not covered by the Medical Assistance Program.

Clients can receive a brand name drug **without** a prior authorization if:

- 1) Only a brand name drug is manufactured.
- 2) A generic drug is not therapeutically equivalent to the brand name drug.
- 3) The Department has determined the final cost of the brand name drug is less expensive.
- 4) The drug is for the treatment of:
  - i. Biologically based mental illness as defined in C.R.S 10-16-104 (5.5);,
  - ii. Treatment of cancer;,,
  - iii. Treatment of epilepsy;,, or
  - iv. Treatment of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome.

Clients may receive a brand name drug **with** a prior authorization if:

- 1) A client has tried the generic equivalent but is unable to continue treatment on the generic drug.
- 2) The physician is of an opinion that a transition to the generic equivalent of a brand-name drug would be unacceptably disruptive to the patient's stabilized drug regimen.

The [Pharmacy Prior Authorization Request form](#) is available in the Pharmacy section of the Department's Web site at <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132>.

## Dispensing Requirements

### Tamper Resistant Prescription Pads

All Medicaid providers are required to use tamper-resistant prescription pads for written prescriptions. This requirement stems from the Social Security Act, 42 U.S.C. 1396b(i)(23), which lists three different characteristics to be integrated into the manufacture of prescription pads. The tamper-resistant prescription pads used by Medicaid providers must meet one of the three characteristics stated in the law. Prescriptions must be written on tamper-resistant prescription pads that meet all three of the stated characteristics. More information about [Tamper-Resistant Prescription Pads/Paper requirements](#) and features can be found in the Pharmacy section of the Department's Web site.

### Compounded Prescriptions

A compounded prescription (a prescription where two or more ingredients are combined to achieve a desired therapeutic effect) must be submitted on the same claim. A prior authorization is only necessary if an ingredient in the compound is subject to prior authorization. Pharmacies may use the number 8 in field 420-DK instead of obtaining a PA for non-covered ingredients to allow the claim to pay for the ingredients that are considered a covered benefit. The Medical Assistance Program does not pay a compounding fee.

## Partial Fills and/or Prescription Splitting

Prescriptions cannot be dispensed in quantities less than the physician ordered unless the quantity ordered is more than a 100-day supply for maintenance medications and 30-day supply for non-maintenance medications. Partial fills are not allowed.

## Emergency Three-Day Supply

In an emergency, when a prior authorization cannot be obtained in time to fill the prescription, pharmacies may dispense a 72-hour supply (3 days) of covered outpatient prescription drugs to an eligible Medical Assistance Program client by calling the Department's PA Helpdesk for approval. The Helpdesk phone number can be found in Appendix P on the Department's Web site. An emergency situation is any condition that is life threatening or requires immediate medical intervention.

## Lost/Stolen/Damaged/Vacation Prescriptions

The State does not pay for early refills when needed for a vacation supply.

The Medical Assistance Program will cover lost, stolen, or damaged medications once per lifetime for each client. Stolen prescriptions will require a copy of the police report to be submitted to the state before approval will be granted. The replacement request and verification must be submitted to the state within 60 days of the last refill of the medication.

## Counseling

A pharmacist or pharmacist designee shall offer counseling regarding the drug therapy to each Medicaid patient with a new prescription. The offer to counsel shall be face-to-face communication whenever practicable or by telephone. A pharmacist shall not be required to counsel a patient or caregiver when the patient or caregiver refuses such consultation. The pharmacist shall keep signatures from Medicaid clients indicating that counseling was offered.

## Override Codes

**Prior Authorization Type Code 1** – Use for emergency only. Effective July 1, 2007, this code is no longer allowed to override a prior authorization requirement. Please see the current policy for processing an emergency three-day supply on page 5.

**Prior Authorization Type Code 2** – Refill too soon. Effective June 1, 2010, this code is no longer an override the refill too soon edit. If a client has a change in dosage, the point of sale system will ignore the refill too soon edit. If a client is going into or out of a nursing home and is in need of medication, the pharmacy must request an authorization from the PA Helpdesk.

**Prior Authorization Type Code 4** – Copay exemption for pregnant/postpartum clients. This code can only be used for female clients who are pregnant or 60 days postpartum to exempt the client from co-payments.

**DAW 1** – Prescriber requests brand. This code is required for brand name products that have a generic equivalent to override FUL reimbursement. A prior authorization may also be necessary if the drug is not excluded from the generic mandate.

## Co-payment Exclusions

Applicable Medical Assistance Program co-payment is automatically deducted from the provider's payment during claims processing. Providers can collect co-payment from the client

at the time of service or establish other payment methods. Services cannot be withheld if the client is unable to pay the co-payment.

**The following categories of clients are exempt from co-payment:**

- CLIENTS WHO ARE AGES 18 AND YOUNGER
- CLIENTS RESIDING IN A NURSING FACILITY
- ALL SERVICES TO WOMEN IN THE MATERNITY CYCLE. THE MATERNITY CYCLE IS THE TIME PERIOD DURING THE PREGNANCY AND SIXTY DAYS POST-PARTUM. PHARMACIES NEED TO USE A MEDICAL CERTIFICATION 4 CODE TO WAIVE THE COPAYMENT FOR WOMEN IN THE MATERNITY CYCLE.

## Reversals

If the Medical Assistance Program client does not pick up the prescription from the pharmacy within 14 calendar days, the prescription must be reversed on the 15th calendar day. The pharmacy must retain a record of the reversal on file in the pharmacy for audit purposes. Pharmacies that have an electronic tracking system shall review prescriptions in will-call status on a daily basis and enter a reversal of prescriptions not picked up within ten (10) days of billing. In no case shall prescriptions be kept in will-call status for more than fourteen (14) days.

## Retention of Records

Source documents and source records used to create pharmacy claims shall be maintained in such a way that all electronic media claims can be readily associated and identified. These source documents, in addition to any work papers and records used to create electronic media claims, shall be retained by the provider for six years and shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the State Department, and the Medicaid Fraud Control Unit and their authorized agents.

## Mail Order

Qualifying Medicaid fee-for-service clients may receive their outpatient maintenance medications from mail order pharmacies.

In order to qualify, a Medicaid client must have:

1. A physical hardship that prohibits him or her from obtaining their maintenance medications from a local pharmacy, **or**
2. Third party insurance that allows the use of a mail order pharmacy to obtain their maintenance medications.

A client or the client's physician must complete and submit an enrollment form to the Department that attests the client meets one of the qualifying criteria.

If a mail order pharmacy submits a pharmacy claim for a Medicaid client that has not enrolled for the mail order benefit, the claim will be denied. The NCPDP edit that will appear at the point-of-sale is an 85, with text indicating that the claim did not process. This denial will appear as edit PB85 on the Provider Claim Report, with information indicating the claim did not process.

Out-of-state mail order pharmacies are permitted to enroll as Medicaid providers but may only mail maintenance medications to clients who have applied for the mail order pharmacy benefit.

Local pharmacies, which are not mail order pharmacies, may continue to occasionally mail any type of outpatient medication to any fee-for-service Medicaid clients without the clients having to enroll for the mail order pharmacy benefit.

## Restricted Products

The Colorado Medical Assistance Program restricts or excludes coverage for some drug categories. More information may be obtained in [Appendix P](#) of the Pharmacy section of the Department’s Web site.

Restricted products by participating companies are covered as follows:

- None* No products in the category are Medical Assistance Program benefits.
- Limited* Prior authorization requests for some products may be approved based on medical necessity.
- All* All products in this category are regular Medical Assistance Program benefits.

Category	Benefits
Anorexia (weight loss)	None
Weight gain	Limited
Cosmetic purposes or hair growth	None
Cough and cold *	Limited
DESI drugs **	None
Non-rebateable products	None
Fertility	None
Non-prescription drugs	Aspirin, Insulin; others Limited
Prenatal vitamins	All for females. None for males.
Other vitamins	Limited
Benzodiazepines	Limited
Barbiturates	Limited
Smoking cessation	Limited

\* *Cough and cold products:* Cough and cold products include combinations of narcotic and non-narcotic cough suppressants, expectorants and/or decongestants. Single agent antihistamines are not considered to be cough and cold products and are regular Medical Assistance Program benefits.

\*\* *DESI drugs:* DESI drugs are products that are declared "less than effective" by the FDA and are not a benefit of the Medical Assistance program.

## Exclusions

The following are not benefits of the Medical Assistance Program:

- DESI DRUGS AND ANY DRUG IF BY ITS GENERIC MAKEUP AND ROUTE OF ADMINISTRATION, IT IS IDENTICAL, RELATED, OR SIMILAR TO A LESS THAN EFFECTIVE DRUG IDENTIFIED BY THE FDA
- DRUGS CLASSIFIED BY THE U.S.D.H.H.S. FOOD AND DRUG ADMINISTRATION AS "INVESTIGATIONAL" OR "EXPERIMENTAL"
- DIETARY NEEDS OR FOOD SUPPLEMENTS (SEE APPENDIX Y FOR A LIST)

- MEDICARE PART D DRUGS FOR PART D ELIGIBLE CLIENTS
- DRUGS MANUFACTURED BY PHARMACEUTICAL COMPANIES NOT PARTICIPATING IN THE STATE MEDICAL ASSISTANCE PROGRAM
- FERTILITY DRUGS
- IV EQUIPMENT (FOR EXAMPLE, VENOPAKS DISPENSED WITHOUT THE IV SOLUTIONS). NURSING FACILITIES MUST FURNISH IV EQUIPMENT FOR THEIR PATIENTS
- PERSONAL CARE ITEMS SUCH AS MOUTH WASH, DEODORANTS, TALCUM POWDER, BATH POWDER, SOAP (OF ANY KIND), DENTIFRICES, ETC.
- SPIRITUOUS LIQUORS OF ANY KIND
- ERECTILE DYSFUNCTION DRUGS

The following are not **pharmacy** benefits of the Medical Assistance Program:

- DRUGS ADMINISTERED IN PHYSICIAN'S OFFICE; THESE MUST BE BILLED BY THE PHYSICIAN AS A MEDICAL BENEFIT USING A 1500 CLAIM FORM OR THE DEPARTMENT'S WEB PORTAL
- DRUGS ADMINISTERED IN CLINICS; THESE MUST BE BILLED BY THE CLINIC USING A 1500 CLAIM FORM OR THE DEPARTMENT'S WEB PORTAL
- DRUGS ADMINISTERED IN A DIALYSIS UNIT ARE PART OF THE DIALYSIS FEE OR MUST BE BILLED USING A 1500 CLAIM FORM OR THE DEPARTMENT'S WEB PORTAL
- DRUGS ADMINISTERED IN THE HOSPITAL ARE PART OF THE HOSPITAL FEE
- DURABLE MEDICAL EQUIPMENT; THESE MUST BE BILLED AS A MEDICAL BENEFIT USING A 1500 CLAIM FORM OR THE DEPARTMENT'S WEB PORTAL

## Fiscal Agent Helpdesk

The Department's fiscal agent provides a support Helpdesk. The Helpdesk is available to answer provider claim submission and basic drug coverage questions (refer to PDCS Pharmacy Support numbers found in Appendix B of the [Appendices](#) located on the Department's Web site).

The Helpdesk is available 24 hours a day seven days a week.

# Pharmacy Claim Billing Instructions

---



The Colorado Medical Assistance Program uses the National Council on Prescription Drug Programs (NCPDP) electronic format and the Pharmacy Claim Form (PCF) to submit prescription drug claims. Both electronic and paper claims are processed by the Prescription Drug Card System (PDCS). PDCS provides claim, provider, eligibility, and prior authorization interfaces with Medicaid Management Information System (MMIS). All electronic claims must be submitted through a pharmacy switch vendor. Claims that cannot be submitted through the vendor must be submitted on paper. The specific rules and requirements regarding electronic and paper claims can be found starting on page 12 in this manual.

## Timely Filing Requirements

Colorado Medical Assistance Program pharmacy claims must be submitted electronically and within the timely filing period, with few exceptions. Timely filing for electronic and paper claim submission is 120 days from the fill date, which is the date of service.

Pharmacies should retrieve their Provider Claim Reports via the File and Report Service (FRS) through the Colorado Medical Assistance Program Web Portal Claims that do not result in the Colorado Medical Assistance Program authorizing reimbursement for services rendered may be resubmitted. If a claim is denied, the pharmacy should follow the procedure set forth below for **rebilling denied claims**. If a resolution is not reached, a pharmacy can **ask for reconsideration** from the Department's fiscal agent. If the reconsideration is denied, the final option is to **appeal the reconsideration**.

## Rebilling Denied Claims

Pharmacies may electronically rebill denied claims when the claim submission is within 120 days of the date of service. Claims that are older than 120 days are still considered timely if received within 60 days of the last denial. Pharmacies should continue to rebill until a final resolution has been reached. Pharmacies must keep records of all claim submissions, denials, and related evidence until final resolution of the claim.

Copies of all forms necessary for submitting claims are also available on the [Pharmacy Billing Procedures and Forms](#) page of the Department's Web site. Instructions on how to complete the PCF are available in this manual. All necessary forms should be submitted to the Department's fiscal agent at:

### **Xerox Claims and PARs Submission**

P.O. Box 30

Denver, CO 80201-0090

There are four exceptions to the 120-day rule: Delayed Processing by Third Party Payers, Retroactive Client Eligibility, Delayed Notification to the Pharmacy of Eligibility and Extenuating Circumstances. Each of these exceptions is detailed below along with the specific instructions for submitting claims.

- **Delayed Processing by Third Party Payers**

The Colorado Medical Assistance Program is the payer of last resort. When timely filing expires due to delays in receiving third party payment or denial documentation, the fiscal agent is authorized to consider the claim as timely if received within 60 days from the date of the third party payment or denial **or** within 365 days of the date of service, whichever occurs first. Pharmacies must complete third party information on the PCF and submit evidence from the third party payer of payment or lack of payment.

- **Retroactive Client Eligibility**

If the timely filing period expires due to a delayed or back-dated client eligibility determination, the claim is considered timely if received within 120 days of the date that the client appears on state eligibility files.

Pharmacies can submit these claims electronically or by paper. If a pharmacy chooses to submit these claims by paper, complete a PCF and attach the Retroactive Backdate Letter from the county to each claim to verify the client's eligibility.

Pharmacies may submit claims electronically by obtaining a prior authorization (PA) through the PA Helpdesk. The pharmacy must fax the Retroactive Eligibility Letter from the county to the PA Helpdesk at 888-772-9696. Within 24 hours, the pharmacy should receive a confirmation fax from the PA Helpdesk. If a confirmation is not received within 24 hours, the pharmacy should call the PA Helpdesk at 800-365-4944. Once the confirmation fax is received, the pharmacy has 120 days from the date the client was granted backdate eligibility to electronically submit claims from the date of eligibility.

- **Delayed notification to the pharmacy of eligibility**

Pharmacies are expected to take appropriate and reasonable action to identify Colorado Medical Assistance Program eligibility in a timely manner. If a pharmacy is made aware of eligibility after 120 days from the date of service, the pharmacy can submit the claim in paper form on the PCF along with Appendix H. Appendix H is a specific form that requests a timely filing extension caused by delayed eligibility notification. Because pharmacies must attach a completed Appendix H to each claim, these claims must be submitted by paper. The Appendix H form can be found in the [Appendices](#) located on the Department's Web site.

- **Extenuating circumstances**

Requests for timely filing waivers for extenuating circumstances must be made in writing and must contain a detailed description of the circumstance that was beyond the control of the pharmacy. Exceptions are granted only when the pharmacy is able to document that appropriate action was taken to meet filing requirements, and that the pharmacy was prevented from filing as the result of extenuating unforeseen and uncontrollable circumstances. Pharmacy employee negligence, employer failure to provide sufficient, well-trained employees, or failure to properly monitor the activities of employees and agents (e.g., billing services) are not considered extenuating circumstances beyond the pharmacy provider's control. The detailed description of the extenuating circumstances must be attached to the PCF and mailed to Xerox.

## Request for Reconsideration

When a pharmacy has exhausted all authorized rebilling procedures and has not been paid for a claim, the pharmacy may submit a Request for Reconsideration to the fiscal agent.

**We recommend that pharmacies contact the Xerox pharmacy benefit management division at (303) 534-0109 before submitting a request for reconsideration.**

Requests for Reconsideration must be filed in writing with the fiscal agent within 60 days of the most recent claim or prior reconsideration denial.

Copies of all Provider Claim Reports, electronic claim rejections, and/or correspondence documenting compliance with timely filing and sixty-day rule requirements must be submitted with the Request for Reconsideration. A Request for Reconsideration will display on the Provider Claim Report as a paid or denied claim without specifying that it is a claim for reconsideration.

An additional request for reconsideration may be submitted within 60 days of the reconsideration denial if information can be corrected or if additional supporting information is available. The resubmitted request must be completed in the same manner as an original reconsideration request.

The Request for Reconsideration Form and instructions are available in the Provider Services [Forms](#) section of the Department Web site.

## Appealing Reconsideration Denials

If a pharmacy disagrees with the final decision of the fiscal agent, the pharmacy may file an appeal with the Office of Administrative Courts. Representation by an attorney is usually required at administrative hearings. Appeals to the Office of Administrative Courts must be filed in writing within 30 days from the mailing date of the reconsideration denial. Appeals may be sent to:

Office of Administrative Courts  
633 Seventeenth Street, Suite 1300  
Denver, Colorado 80202.

## Paper Claim Submission Requirements

With few exceptions, providers are required to submit claims electronically. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

**Exceptions allowing claims to be processed for payment on paper include:**

- PROVIDERS WHO CONSISTENTLY SUBMIT FIVE OR FEWER CLAIMS PER MONTH
- CLAIMS THAT ARE MORE THAN 120 DAYS FROM THE DATE OF SERVICE THAT REQUIRE SPECIAL ATTACHMENTS
- RECONSIDERATION CLAIMS

Providers can submit only one claim per submission on the PCF; however, compound claims can be submitted. Providers must submit accurate information. The use of inaccurate or false information can result in the reversal of claims.

The PCF should be submitted to the Department's fiscal agent at:

**Xerox Claims and PARs Submission**

P.O. Box 30

Denver, CO 80201-0090

Below are the completion instructions for the Colorado Pharmacy Claim Form (PCF-2) for Pharmacy Providers. The form is one-sided and requires an authorized signature. Providers must follow the instructions below and may only submit one (prescription) per claim. The claim may be a multi-line compound claim. If there is more than a single payer a D.0 electronic transaction must be submitted.

\*\*\* Please note: The format for entering a date is different than the date format in the POS system \*\*\*

### Instructions for Completing the Pharmacy Claim Form

FIELD	VALUE	COMMENT
Client's Mcaid ID #	Client's 7-character Medical Assistance Program ID	Required
Group ID	Colorado	Default value on claim form
Relationship Code	1=Cardholder	Default value on claim form
Client's Name	Last, First, MI	Required
Other Cov Code	0=Not specified 1=No other cov identified 2=Other cov exists-Pymt collected 3=Other cov exists-Claim not covered 4=Other cov exists-Pymt not collected	Required when submitting a claim for client w/ other cov
Client's DOB	MM/DD/YYYY	Required

Svc Prov ID	NPI=National Provider Identifier	Required
Svc Prov ID Qual	01=NPI-National Provider Identifier	Required

Prescriber's Last Name	Last Name of Prescriber	Required
Prescriber's Phone #	Prescriber's Phone #	Required
Prescriber's ID	Prescriber's NPI, CO State License or DEA #	Required
Prescriber's ID Qualifier	01=National Provider Identifier 08=CO State License # 12=Drug Enforcement Administration (DEA#)	Required
Prescription #	Prescription # Assigned by Pharmacy	Required
Date Written	MM/DD/YYYY	Required
Date Filled	MM/DD/YYYY	Required
Fill #	00=Original Fill 01-99=# of Refills	Required
Prescription # Qualifier	0=Blank 1=Rx Billing	Required
Days Supply	# of Days Prescription is Prescribed	Required
DAW Codes	0=No Generic Available or Generic Medication 1=Physician Requested	Required when the valid values are appropriate for submission of the claim
PA Type Code	0=Not Specified 4=Pregnant or 60 Days Postpartum	Required when the client is pregnant or 60 days postpartum

Quantity Prescribed	Metric Decimal Quantity	Required-If claim is for a compound prescription, list total # of units for claim
Quantity Dispensed	Metric Decimal Quantity	Required-If claim is for a compound prescription, list total # of units for claim
Product ID	NDC #	Required-If claim is for a compound prescription, enter "COMPOUND RX"
Product ID Qualifier	00=If Claim is a Compound Claim      03=National Drug Code (NDC)	Required-If claim is for a compound prescription , enter "00"
Submitted Ingredient Cost		Required-Enter total ingredient costs even if claim is for a compound prescription
Total Charge		Required-Pharmacy's Usual and Customary Charge
Gross Amount Due		Required

Other Payer Cov Type	01=Primary	Required if Other Cov Code equals 2, 3, or 4
Other Payer Date	MM/DD/YYYY	Required if Other Cov Code equals 2, 3, or 4
Other Payer \$ Paid		Required if Other Cov Code equals 2, 3, or 4
Other Payer \$ Paid Qualifier	02=Shipping      06=Cognitive Service 03=Postage      07=Drug Benefit 04=Administrative   09=Compound Preparation Cost 05=Incentive      10=Sales Tax	Required if Other Cov Code equals 2, 3, or 4
Other Payer Reject Code	Value from Prior Payer	Required if Other Cov Code equals 3
Other Payer Patient Responsibility \$	Value from Prior Payer	Required if Other Cov Code equals 4
Other Payer Patient Responsibility \$ Qualifier	01=Amount Applied to Periodic Deductible 05=Amount of Copay 06=Patient Pay Amount (only if Prior Payer was still in NCPDP version 5.1) 07=Amount of Coinsurance	Required if Other Cov Code equals 4
Compound Claim	Blank      1=Not a Compound Claim 0=Not Specified   2=Claim is a Compound Claim	Required when claim is for a compound prescription
Diagnosis Code Qualifier	01=ICD9 Code on Prescription      02=ICD10 (adoption date to be announced)	
Diagnosis Code	ICD9 Code on Prescription      ICD10 (adoption date to be announced)	Required if this information can be used in place of prior auth
RX Override	8=Process Compound Claim for Approved Ingredients * In the future, Colorado plans to utilize other Rx Override fields.	Conditional-Needed to process claim for approved ingredients when claim is for a compound prescription

If the claim is a compound claim, complete the bottom section of the claim form to indicate each ingredient name, NDC quantity, and cost. Remember that there is a limit of one prescription per claim form.

FIELD	VALUE	COMMENT
Ingredient Name	Ingredient Name	Required when the claim is for a compound prescription

NDC	NDC Number of the Ingredient	Required when the claim is for a compound prescription
Quantity	Metric Decimal Quantity Dispensed	Required when the claim is for a compound prescription
Ingredient Cost Submitted		Required when the claim is for a compound prescription

## Electronic Claim Submission Requirements

Interactive claim submission is a real-time exchange of information between the provider and the Colorado Medical Assistance Program. The provider creates interactive claims one at a time and transmits them by toll-free telephone through a switch company to the Colorado Medical Assistance Program fiscal agent claims processor. The Medical Assistance Program fiscal agent claims processor reviews the claim and immediately returns a status of paid or denied for each transaction to the provider's personal computer. If the claim is denied, the fiscal agent claims processor sends one or more denial reason(s) that identify the problem(s).

Interactive claim submission must comply with Colorado D.O Requirements. Providers must submit accurate information. The use of inaccurate or false information can result in the reversal of claims.

- An optional data element means that the user should be prompted for the field but does not have to enter a value.
- Drug Utilization Review (DUR) information, if applicable, will appear in the message text of the response.
- Electronic claim submissions must meet timely filing requirements.

### Transaction Header Segment:

*Mandatory in all cases*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	610084	M	
1Ø2-A2	Version/Release Number	5.1	M	
1Ø3-A3	Transaction Code	B1 = Billing B2 = Reversals B3 = Rebill	M	
1Ø4-A4	Processor Control Number	DRCOPROD = Production DRCOACCP = Test	M	

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø9-A9	Transaction Count	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	
2Ø2-B2	Service Provider ID Qualifier	01 – NPI number	M	
2Ø1-B1	Service Provider ID	NPI number	M	
4Ø1-D1	Date of Service	CCYYMMDD	M	
11Ø-AK	Software Vendor/Certification ID	This will be supplied by the provider’s software vendor	M	If no number is supplied, populate with zeros

**Patient Segment:**

*Mandatory*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø1	M	Patient Segment
331-CX	Patient ID Qualifier	Blank = Not Specified 01=Social Security Number 02=Driver’s License Number 03=U.S. Military ID 99=Other	NA	<i>Not used by Colorado</i>
332-CY	Patient ID		NA	<i>Not used by Colorado</i>
304-C4	Date of Birth	CCYYMMDD	R	
305-C5	Patient Gender Code	0=Not specified 1=Male 2=Female	R	
310 –CA	Patient First Name	Up to 12 characters	NA	<i>Not used by Colorado</i>
311 – CB	Patient Last Name	Up to 15 characters	NA	<i>Not used by Colorado</i>
322-CM	Patient Street Address	Up to 30 characters	NA	<i>Not used by Colorado</i>
323-CN	Patient City Address	Up to 20 Characters	NA	<i>Not used by Colorado</i>
324-CO	Patient State/Province Address	2 characters	NA	<i>Not used by Colorado</i>
325-CP	Patient Zip/POSTAL Zone	Up to 15 characters	NA	<i>Not used by Colorado</i>
326-CQ	Patient Phone Number	Up to 10 characters	NA	<i>Not used by Colorado</i>

Field	NCPDP Field Name	Value	M/R/RW	Comment
307-C7	Patient Location	<b>0=Not specified</b> <b>01=Home</b> 02=Inter-Care <b>03=Nursing Home</b> 04=Long Term/Extended Care 05=Rest Home <b>06=Boarding Home</b> 07=Skilled Care Facility 08=Sub-Acute care Facility 09=Acute Care Facility 10=Outpatient 11=Hospice	R	
333-CZ	Employer ID		NS	Not supported
334-1C	Smoker/Non-Smoker Code		NS	Not supported
335-2C	Pregnancy Indicator	Blank=Not Specified 1=Not pregnant 2=Pregnant	NA	<i>Not used by Colorado</i>

**Insurance Segment:**

*Mandatory*

111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID	Client's 7 character alpha-numeric Medical Assistance Program ID	M	
312-CC	Cardholder First Name	12 characters	NA	<i>Not used by Colorado</i>
313-CD	Cardholder Last Name	20 Characters	NA	<i>Not used by Colorado</i>
314-CE	Home Plan		NS	Not supported
524-FO	Plan ID	8 characters	NA	<i>Not used by Colorado</i>
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	NA	<i>Not used by Colorado</i>
336-8C	Facility ID		NS	Not supported
301-C1	Group ID	Colorado	R	
306-C6	Patient Relationship Code	<b>1 = Cardholder</b> 2 = Spouse 3=Child 4=Other	RW	Always use '1' if the systems requires an entry

**Claim Segment:**

*Mandatory*

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	
4Ø2-D2	Prescription/Service Reference Number	Number assigned by the pharmacy	M	
436-E1	Product/Service ID Qualifier	03 = National Drug Code	M	
4Ø7-D7	Product/Service ID	NDC Number	M	
456-EN	Associated Prescription/ Service Reference #		NA	<i>Not used by Colorado</i>
457-EP	Associated Prescription/Service Date		NA	<i>Not used by Colorado</i>
458-SE	Procedure Modifier Count		NA	<i>Not used by Colorado</i>
459-ER	Procedure Modifier Code Count		NA	<i>Not used by Colorado</i>
442-E7	Quantity Dispensed	Metric Decimal Quantity	R	
403-D3	Fill Number	0 = Original Dispensing 1-99 = Number of refills	R	
405-D5	Days Supply		R	
406-D6	Compound Code	0 = Not specified 1= Not a compound <b>2 = Compound</b>	RW	Required when submitting a claim for a compound
408-D8	Dispense as Written (DAW)	<b>0=Default, no product selection indicated</b> <b>1=Physician request</b> 2=Patient request 3=Pharmacist request 4=Generic out of stock (temp) 5=Brand used as generic 6=Override 7=Brand mandated by law 8=Generic not available in marketplace 9=Not used	RW	Colorado only recognizes DAW code 0 and 1. DAW is required when the provider requires the brand name to be dispensed.
414-DE	Date Prescription Written	CCYYMMDD	R	
415-DF	Number of Refills Authorized	0=Not Specified 1-99=number of refill	NA	<i>Not used by Colorado</i>

Field #	NCPDP Field Name	Value	M/R/RW	Comment
419-DJ	Prescription Origin Code	0=Not specified 1=Written 2=Telephone 3=Electronic 4=Facsimile	NA	<i>Not used by Colorado</i>
420-DK	Submission Clarification Code	0=Not specified, default 1=No override 2=Other override 3=Vacation Supply 4=Lost Prescription 5=Therapy Change 6=Starter Dose 7=Medically Necessary <b>8=Process compound for Approved Ingredients</b> 9=Encounters 99=Other	RW	"8" required to allow payment for covered ingredients and ignore and not pay for non-covered ingredients
460-ET	Quantity Prescriber		NS	Not used, use 442-E7
308-C8	Other Coverage Code	<b>0=Not Specified</b> 1=No other Coverage Identified <b>2=Other coverage exists-payment collected</b> <b>3=Other coverage exists-this claim not covered</b> 4=Other coverage exists-payment not collected 5=Managed care plan denial 6=Other coverage exists, not a participating provider 7=Other Coverage exists-not in effect at time of service 8=Claim is a billing for a co-pay	RW	Required when submitting a claim for a recipient who has other coverage
429-DT	Unit Dose Indicator	0=Not specified 1=Not Unit Dose 2=Manufacturer Unit Dose 3=Pharmacy Unit Dose	NA	<i>Not used by Colorado</i>

Field #	NCPDP Field Name	Value	M/R/RW	Comment
453-EJ	Orig Prescribed Product/Service ID Qual	01=Universal Product Code (UPC) 03=National Drug Code (NDC)	NA	<i>Not used by Colorado</i>
445-EA	Originally Prescribed Product/Service Code		NA	<i>Not used by Colorado</i>
446-EB	Originally Prescribed Quantity		NA	<i>Not used by Colorado</i>
330-CW	Alternate ID		NS	Not supported
454-EK	Scheduled prescription ID Number		NS	Not supported
418-DI	Level of Service		NA	<i>Not used by Colorado</i>
461-EU	Prior Authorization Type Code	0 = Not specified 1 = Prior Authorization <b>2 = Medical Certification</b> 3=EPSDT (Early Periodic Screening Diagnosis Treatment) <b>4=Exemption from Copay</b> 5=Exemption from Rx 6=Family Plan 7 = AFDC (Aid to Families with Dependent Children) 8=Payer Defined Exemption	RW	Enter a '2' to override a 'refill to soon' denial only when there has been an increase in dosage  Enter '4' to indicate that the client is in the maternity cycle
462-EV	Prior Authorization Number Submitted		NA	<i>Not used by Colorado</i>
463-EW	Intermediary Authorization Type ID		NA	<i>Not used by Colorado</i>
464-EX	Intermediary Authorization ID		NA	<i>Not used by Colorado</i>
343-HD	Dispensing Status		NA	<i>Not used by Colorado</i>
344-HF	Quantity Intended to be Dispensed		NA	<i>Not used by Colorado</i>
345-HG	Days Supply Intended to be Dispensed		NA	<i>Not used by Colorado</i>
600-28	Unit of Measure		NS	Not supported

**Pharmacy Provider Segment:**

*Mandatory*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø2	M	Pharmacy Provider Segment
465-EY	Provider ID Qualifier	Blank=Not specified 01=Drug Enforcement Administration (DEA) 02=State License 03=Social Security Number (SSN) 04=Name 05=National Provider Identifier (NPI) 06=Health Industry Number (HIN) 07=State Issued 99=Other	NA	<i>Not used by Colorado</i>
444-E9	Provider ID		NA	<i>Not used by Colorado</i>

**Prescriber Segment:**

*Mandatory*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø3	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	01=NPI number 08=State License # 12=DEA#	R	
411-DB	Prescriber ID	NPI number State License Number Drug Enforcement Agency (DEA) Number	R	
467-1E	Prescriber Location Code		NS	Not supported
427-DR	Prescriber Last Name	15 characters	NA	<i>Not used by Colorado</i>
498-PM	Prescriber Phone Number	10 characters	NA	<i>Not used by Colorado</i>

Field #	NCPDP Field Name	Value	M/R/RW	Comment
468-2E	Primary Care Provider ID Qualifier	Blank=Not Specified 01=National Provider ID (NPI) 02=Blue Cross 03=Blue Shield 04=Medicare 05=Medical Assistance Program 06=UPIN 07=NCPDP Provider ID 08=State License 09=Champus 10=Health Industry Number (HIN) 11=Federal Tax ID 12=Drug Enforcement Administration (DEA) 13=State Issued 14=Plan Specific 99=Other	NA	<i>Not used by Colorado</i>
421-DL	Primary Care Provider ID	15 characters	NA	<i>Not used by Colorado</i>
469-H5	Primary care Provider Location Code		NS	Not supported
470-4E	Primary Care Provider Last Name		NS	Not supported

**COB/Other Payments Segment:**

*Mandatory*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø5	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count		M	
338-5C	Other Payer Coverage Type		M (Repeating)	



Field #	NCPDP Field Name	Value	M/R/RW	Comment
339-6C	Other Payer Id Qualifier	Blank=Not Specified 01=National Payer ID 02=Health Industry Number 03=Bank Information Number (BIN) 04=National Association of Insurance Commissioners (NAIC) 09=Coupon 99-Other	NA	<i>Not used by Colorado</i>
340-7C	Other Payer ID	10 characters	NA	<i>Not used by Colorado</i>
443-E8	Other Payer Date	CCYYMMDD	RW (Repeating)	Required when there is payment from another source
431-DV	Other Payer Amount Paid	\$\$\$\$\$\$cc	RW	Required when there is payment from another source
471-5E	Other Payer Reject Count	2 Characters	NA	<i>Not used by Colorado</i>
472-6E	Other Payer Reject Code		NA	<i>Not used by Colorado</i>

**Workers' Compensation Segment:**  
*Not used by Colorado*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø6	NA	Workers' Compensation Segment
434-DY	Date of Injury		NA	
315-CF	Employer Name		NS	Not supported
316-CG	Employer Street Address		NS	Not supported
317-CH	Employer City Address		NS	Not supported
318-CI	Employer State/Province ID		NS	Not supported
319-CJ	Employer Zip/Postal Zone		NS	Not supported
320-CK	Employer Phone Number		NS	Not supported
321-CL	Employer Contact Name		NS	Not supported
327-CR	Carrier ID		NS	Not supported
435-DZ	Claim/Reference ID		NS	Not supported

**DUR/PPS Segment:**

*Optional*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø8	M	DUR/PPS Segment
473-7E	DUR/PPS Code counter		NA	<i>Not used by Colorado</i>
439-E4	Reason For Service Code	See list of valid values on page 28	RW (Repeating)	Required when there is a conflict to resolve or reason for service to be explained
440-E5	Professional Service Code	See list of valid values on page 29	RW	Required when there is a professional service to be identified
441-E6	Result of Service Code	See list of valid values on page 29	RW	Required when there is a result of service to be submitted
478-8E	DUR/PPS Level of Effort		NA	<i>Not used by Colorado</i>
475-J9	DUR Co-Agent ID Qualifier		NA	<i>Not used by Colorado</i>
476-H6	DUR Co-Agent ID		NA	<i>Not used by Colorado</i>

**Pricing Segment:**

*Mandatory*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	11	M	Pricing Segment
409-D9	Ingredient Cost Submitted		R	
412-DC	Dispensing Fee Submitted		NA	<i>Not used by Colorado</i>
477-BE	Professional Service Fee Submitted		NA	<i>Not used by Colorado</i>
433-DX	Patient Paid Amount		NA	<i>Not used by Colorado</i>
481-HA	Flat Sales Tax Amount Submitted		NA	<i>Not used by Colorado</i>
482-GE	Percentage Sales Tax Amount Submitted		NA	<i>Not used by Colorado</i>
484-JE	Percentage Sales Tax Basis Submitted	Blank=Not specified 01=Gross Amount Due 02=Ingredient Cost 03=Ingredient Cost + Dispensing Fee	NA	<i>Not used by Colorado</i>
426-DQ	Usual and Customary Charge		R	
430-DU	Gross Amount Due	s9(6)v99	NA	<i>Not used by Colorado</i>

Field #	NCPDP Field Name	Value	M/R/RW	Comment
423-DN	Basis of Cost Determination	Blank=Not specified 00=Not specified 01=AWP (Average Wholesale Price) 02=Local Wholesaler 03=Direct 04=EAC (Estimated Acquisition Cost) 05=Acquisition 06=MAC (Maximum Allowable Cost) 07=Usual & customary 09=Other	NA	<i>Not used by Colorado</i>

**Coupon Segment:**

*Segment is not supported*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø9	NS	Coupon Segment
485-KE	Coupon Type		NS	
486-ME	Coupon Number		NS	
487-NE	Coupon Value Amount		NS	

**Compound Segment:**

*Mandatory*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	1Ø	M	Compound Segment
45Ø-EF	Compound Dosage Form Description Code		M	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
451-EG	Compound Dispensing Unit Form Indicator		M	1=Each 2=Grams 3=Milliliters
452-EH	Compound Route of Administration		M	1=Buccal 2=Dental 3=Inhalation 4=Injection 5=Intraperitoneal 6=Irrigation 7=Mouth/Throat 8=Mucous Membrane 9=Nasal 1Ø=Ophthalmic 11=Oral 12=Other/Miscellaneous 13=Otic 14=Perfusion 15=Rectal 16=Sublingual 17=Topical 18=Transdermal 19=Translingual 2Ø=Urethral 21=Vaginal 22=Enteral
447-EC	Compound Ingredient Component (Count)		M (Repeating)	
488-RE	Compound Product ID Qualifier	Ø1=Universal Product Code (UPC) Ø3=National Drug Code (NDC)	M (Repeating)	
489-TE	Compound Product ID		M (Repeating)	
448-ED	Compound Ingredient Quantity	9(7)v999	M (Repeating)	

Field #	NCPDP Field Name	Value	M/R/RW	Comment
449-EE	Compound Ingredient Drug Cost		NA	<i>Not used by Colorado</i>
490-UE	Compound ingredient basis of Cost Determination	Blank=Not specified 01=AWP 02=Local Wholesaler 03=Direct 04=EAC 05=Acquisition 06=MAC 07=Usual & customary 09=Other	NA	<i>Not used by Colorado</i>

**Prior Authorization Segment:**

*Not used by Colorado*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	12	NA	Prior Authorization Segment
498-PA	Request Type		NA	
498-PB	Request Period Date –Begin		NA	
498-PC	Request Period Date- End		NA	
498-PD	Basis of Request		NA	
498-PE	Authorized Representative First Name		NA	
498-PF	Authorized Representative Last Name		NA	
498-PG	Authorized Representative Street Address		NA	
498-PH	Authorized Representative City Address		NA	
498-PJ	Authorized Representative State/Province Address		NA	
498-PK	Authorized Representative Zip/Postal Code		NA	
498-PY	Prior Authorization Number Assigned		NA	
503-F3	Authorization Number		NA	
498-PP	Prior Authorization Supporting Documentation		NA	

**Clinical Segment:**

*Optional*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	13	NA	Clinical Segment
491-VE	Diagnosis Code Count		NA	
492-WE	Diagnosis Code	01 = International Classification of Diseases (ICD-9)	NA	
424-DO	Diagnosis Code		RW	Required when submitting an ICD-9 code
493-XE	Clinical Information Counter		NA	
494-ZE	Measurement Date		NA	
495-H1	Measurement Time		NA	
496-H2	Measurement Dimension		NA	
497-H3	Measurement Unit		NA	
499-H4	Measurement Value		NA	

**DUR Codes**

**Reason for Service Codes (DUR Conflict Codes)**

Code	Meaning	Code	Meaning
AT	Additive Toxicity	LD	Low Dose alert
CH	Call Help Desk	LR	Under Use Precaution
DA	Drug Allergy Alert	MC	Drug Disease Precaution
DC	Inferred Drug Disease Precaution	MN	Insufficient Duration Alert
DD	Drug-Drug Interaction	MX	Excessive Duration Alert
DF	Drug Food Interactions	OH	Alcohol Precaution
DI	Drug Incompatibility	PA	Drug Age Precaution
DL	Drug Lab conflict	PG	Drug Pregnancy alert
DS	Tobacco use precaution	PR	Prior Adverse drug reaction
ER	Over Use precaution	SE	Side effect alert
HD	High Dose alert	SX	Drug gender alert
IC	Iatrogenic condition alert	TD	Therapeutic Duplication
ID	Ingredient Duplication		

**Professional Service Codes (Intervention Codes)**

Code	Meaning	Code	Meaning
M0	MD Interface	R0	Pharmacist reviewed
P0	Patient Interaction		

**Result of Service Codes (DUR Outcome Codes)**

Code	Meaning	Code	Meaning
1A	Filled – False Positive	1F	Filled – Different quantity
1B	Filled as is	1G	Filled after prescriber approval
1C	Filled with different dose	2A	Not Filled
1D	Filled with different directions	2B	Not Filled – Directions Clarified

## NCPDP VERSION 5.1 PAYER SHEET – B2 (Reversal) Transactions

Payer Name: Colorado Medical Assistance Program	Date: August 1, 2009
Plan Name/Group Name: Colorado Medical Assistance Program	
Processor: ACS, Inc.	Switch:
Effective as of: August 1, 2009	Version/Release #: 5.1

Transaction Code	Transaction Name
B2	Reversals



**Transaction Header Segment:**

*Mandatory in all cases*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	610084	M	
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B2	M	
1Ø4-A4	Processor Control Number	DRCOPROD for Production DRCOACCP for Acceptance	M	
1Ø9-A9	Transaction Count	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	For B2 transactions, the transaction count must be a value of 1, 2, 3 or 4
2Ø2-B2	Service Provider ID Qualifier	01 = NPI number	M	
2Ø1-B1	Service Provider ID	NPI number	M	
4Ø1-D1	Date of Service	CCYYMMDD	M	
11Ø-AK	Software Vendor/Certification ID	This is the ID assigned by the processor to identify the software source. This ID verifies that the software is certified.	M	

**Insurance Segment:**

*Mandatory*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID	Client's 7 character alpha-numeric Medical Assistance Program Number	M	
312-CC	Cardholder First Name		NA	
313-CD	Cardholder Last Name		NA	
309-C9	Eligibility Clarification Code		NA	
301-C1	Group ID	Colorado	R	
306-C6	Patient Relationship Code	1 = Cardholder	R	

**Patient Segment:**

*Not Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø1	NS	Patient Segment

**Claim Segment:**

*Mandatory*

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	
4Ø2-D2	Prescription/Service Reference Number		M	
436-E1	Product/Service ID Qualifier	03= NDC	M	
4Ø7-D7	Product/Service ID	NDC Number	M	
111-AM	Segment Identification	Ø7	M	Claim Segment
442-E7	Quantity Dispensed	Metric Decimal Quantity	R	
403-D3	Fill Number		R	
405-D5	Days Supply		R	
406-D6	Compound Code	2 = Compound	RW	Required when reversing a claim for a compound
414-DE	Date Prescription Written		R	
308-C8	Other Coverage Code	0=Not Specified 1=No other Coverage Identified <b>2=Other coverage exists-payment collected</b> <b>3=Other coverage exists-this claim not covered</b> 4=Other coverage exists-payment not collected 5=Managed care plan denial 6=Other coverage exists, not a participating provider 7=Other Coverage exists-not in effect at time of service 8=Claim is a billing for a co-pay	R	

Field	NCPDP Field Name	Value	M/R/RW	Comment
343-HD	Dispensing Status		NA	Not used by Colorado
344-HF	Quantity Intended to be Dispensed		NA	Not used by Colorado
345-HG	Days Supply Intended to be Dispensed		NA	Not used by Colorado

**Pharmacy Provider Segment:**

*Not Supported for B2 Transactions*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø2	NS	Pharmacy Provider Segment

**Prescriber Segment:**

*Not Supported for B2 Transactions*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø3	NS	Prescriber Segment

**COB/Other Payments Segment:**

*Not Supported for B2 Transactions*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø5	NS	COB/Other Payments Segment

**Workers' Compensation Segment:**

*Not Supported for B2 Transactions*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø6	NS	Workers' Compensation Segment



**DUR/PPS Segment:**

*Not Supported for B2 Transactions*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø8	NS	DUR/PPS Segment

**Pricing Segment:**

*Not Supported for B2 Transactions*

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

**Coupon Segment:**

*Not Supported for B2 Transactions*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø9	NS	Coupon Segment

**Compound Segment:**

*Not Supported for B2 Transactions*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	1Ø	NS	Compound Segment

**Prior Authorization Segment:**

*Not Supported for B2 Transactions*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	12	NS	Prior Authorization Segment

**Clinical Segment:**

*Not Supported for B2 Transactions*

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	13	NS	Clinical Segment



# D.0

## GENERAL INFORMATION

The following are the Payer Sheets for D.0. Effective January 1, 2012, pharmacy transactions must meet D.0 requirements. Pharmacies must code their systems for Colorado D.0 transactions using the information provided below.

### TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name
B1	Billing
B3	Rebill

### FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	<b>M</b>	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	<b>R</b>	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	<b>RW</b>	"Required when". The situations designated have qualifications for	Yes

Payer Usage Column	Value	Explanation	Payer Situation Column
		usage ("Required if x", "Not required if y").	

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

**CLAIM BILLING/CLAIM REBILL TRANSACTION**

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

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN NUMBER	610084	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	DRCOPROD = Production	M	
1Ø9-A9	TRANSACTION COUNT	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	

	Transaction Header Segment			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = NPI	M	
201-B1	SERVICE PROVIDER ID	NPI Number	M	
401-D1	DATE OF SERVICE	CCYYMMDD	M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	This will be provided by the provider's software vender	M	If no number is supplied, populate with zeros

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

	Insurance Segment Segment Identification (111-AM) = "04"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID	Client's 7 character alpha-numeric Medical Assistance Program ID	M	
301-C1	GROUP ID	Colorado	R	
306-C6	PATIENT RELATIONSHIP CODE	1=Cardholder	R	

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

	<b>Patient Segment</b> <b>Segment Identification (111-AM) = "Ø1"</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø4-C4	DATE OF BIRTH	CCYYMMDD	R	
3Ø5-C5	PATIENT GENDER CODE	Ø=Not Specified 1=Male 2=Female	R	
311-CB	PATIENT LAST NAME		R	Required field in D.0
335-2C	PREGNANCY INDICATOR	Blank=Not Specified 1=Not pregnant 2=Pregnant	RW	Required when submitting a claim for a pregnant member
384-4X	PATIENT RESIDENCE	Ø=Not specified 1=Home 3=Nursing Facility 4=Assisted Living Facility 6=Group Home 9=Intermediate Care Facility/Mentally Retarded 11=Hospice 15=Correctional Institution	R	

<b>Claim Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
This payer does not support partial fills	X	

Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Number assigned by the pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code	M	
4Ø7-D7	PRODUCT/SERVICE ID	NDC Number	M	
442-E7	QUANTITY DISPENSED	Metric Decimal Quantity	R	
4Ø3-D3	FILL NUMBER	Ø = Original Dispensing 1-99 = Number of refills	R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	1 = Not a compound 2 = Compound	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Ø = No product selection indicated 1 = Physician request	R	All other DAW Codes will deny
414-DE	DATE PRESCRIPTION WRITTEN	CCYYMMDD	R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	Required if Submission Clarification Code (42Ø-DK) is used.
42Ø-DK	SUBMISSION CLARIFICATION CODE	8 = Process Compound for Approved Ingredients	RW	"8" Required to allow payment for covered ingredients and ignore and not pay for non-covered ingredients in a compound

Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø8-C8	OTHER COVERAGE CODE	Ø=Not Specified 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 (this value will be accepted beginning January 1, 2012).	RW	Medicaid is always the payer of last resort. In order to bill Medicaid for claims where the client has a third party insurer, pharmacies must first bill the third party insurer prior to billing Medicaid.  Completion of this field is required when submitting a claim for a recipient who has other coverage.  <b>Refer to the Other Coverage Code Training Documents available on the <a href="#">Pharmacy</a> section of the Department's Web site at <a href="http://colorado.gov/hcpf">colorado.gov/hcpf</a>.</b>
461-EU	PRIOR AUTHORIZATION TYPE CODE	Ø = Not specified 4 = Exemption from Copay	RW	Enter '4' to indicate that the client is in the maternity cycle
995-E2	ROUTE OF ADMINISTRATION	SNOMED CT Value	RW	Required when the Rx is a compound  New Field – replaces 452-EH in 5.1 Compound Segment

Pricing Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
409-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		RW	Required if necessary as component part of Gross Amount Due
426-DQ	USUAL AND CUSTOMARY CHARGE		R	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.
430-DU	GROSS AMOUNT DUE		R	

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	Prescriber Segment Segment Identification (111-AM) = "03"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
466-EZ	PRESCRIBER ID QUALIFIER	01=National Provider Identifier (NPI) 08=State License # 12=DEA#	R	
411-DB	PRESCRIBER ID	NPI State License Number	R	

	<b>Prescriber Segment</b> <b>Segment Identification (111-AM) = "Ø3"</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
		Drug Enforcement Agency (DEA) Number		

<b>Coordination of Benefits/Other Payments Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill</b> If Situational, <i>Payer Situation</i>
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		

If the Payer supports the Coordination of Benefits/Other Payments Segment, only one scenario method shown above may be supported per template. The template shows the Coordination of Benefits/Other Payments Segment that must be used for each scenario method. The Payer must choose the appropriate scenario method with the segment chart, and delete the other scenario methods with their segment charts. See section [Coordination of Benefits \(COB\) Processing](#) for more information.

	<b>Coordination of Benefits/Other Payments Segment</b> <b>Segment Identification (111-AM) = "Ø5"</b>			<b>Claim Billing/Claim Rebill</b>
				Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
338-5C	OTHER PAYER COVERAGE TYPE	Blank=Not Specified Ø1=Primary Ø2=Secondary - Second Ø3=Tertiary - Third Ø4=Quaternary - Fourth Ø5=Quinary - Fifth	M	
443-E8	OTHER PAYER DATE	CCYYMMDD	RW	Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	Required if Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø1=Delivery Ø2=Shipping Ø3=Postage Ø4=Administrative Ø5=Incentive Ø6=Cognitive Service Ø7=Drug Benefit Ø9=Compound Preparation Cost 1Ø=Sales Tax	RW	Required when there is payment from another source.  Required if Other Payer Amount Paid (431-Dv) is used.
431-DV	OTHER PAYER AMOUNT PAID	\$\$\$\$\$\$cc	RW	Required if other payer has approved payment for some/all of the billing.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	Required if Other Payer Reject Code (472-6E) is used.  <i>Payer Requirement:</i> Required if OCC = 3
472-6E	OTHER PAYER REJECT CODE		RW	Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered).
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.  <i>Payer Requirement:</i> Required if OCC = 4
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø1=Amount Applied to Periodic Deductible (517-FH) Ø2=Amount Attributed to Product Selection/Brand Drug (134-UK) Ø3=Amount Attributed to Sales Tax (523-FN) Ø4=Amount Exceeding Periodic Benefit Maximum (52Ø-FK) Ø5=Amount of Copay (518-FI) Ø6=Patient Pay Amount (5Ø5-F5)	RW	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.  <i>Payer Requirement:</i> Required if OCC = 4. Colorado will only reimburse for amounts submitted with qualifiers Ø1, Ø5 and Ø7.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"				Claim Billing/Claim Rebill  Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		Ø7=Amount of Coinsurance (572-4U) Ø8=Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) Ø9=Amount Attributed to Health Plan Assistance Amount (129-UD) 1Ø=Amount Attributed to Provider Network Selection (133-UJ) 11=Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) 12=Amount Attributed to Coverage Gap (137-UP) 13=Amount Attributed to Processor Fee (571-NZ)		
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	\$\$\$\$\$\$\$\$cc	RW	<i>Payer Requirement:</i> Required if OCC = 4

DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is situational	X	

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	Required if DUR/PPS Segment is used.
439-E4	REASON FOR SERVICE CODE	See Attached list of valid values	RW	Required when there is a conflict to resolve or reason for service to be explained.
44Ø-E5	PROFESSIONAL SERVICE CODE	See Attached list of valid values	RW	Required when there is a professional service to be identified.
441-E6	RESULT OF SERVICE CODE	See Attached list of valid values	RW	Required when There is a result of service to be submitted.

Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is situational	X	Required when billing for a compound

	Compound Segment Segment Identification (111-AM) = "1Ø"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	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	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	1=Each 2=Grams 3=Milliliters	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 dients	M	

Compound Segment Segment Identification (111-AM) = "1Ø"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø1=Universal Product Code (UPC) Ø3=National Drug (NDC)	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY	9(7)v999	M	

Clinical Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is situational	X	Required for coverage of certain drugs in place of prior authorization as identified on State website

Clinical Segment Segment Identification (111-AM) = "13"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DØ) are used.
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1 = ICD9 Ø2 = ICD1Ø	RW	Required if Diagnosis Code (424-DØ) is used.
424-DO	DIAGNOSIS CODE	ICD9 ICD1Ø	RW	Required if this field could result in different coverage, pricing, patient financial responsibility,

	<b>Clinical Segment Segment Identification (111-AM) = "13"</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usag e</i>	<i>Payer Situation</i>
				and/or drug utilization review outcome.  Required if this information can be used in place of prior authorization.

\*\* End of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template\*\*

## Response Claim Billing/Claim Rebill Payer Sheet Template

### Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) Response

**\*\* Start of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template\*\***

CLAIM BILLING/CLAIM REBILL PAID (OR DUPLICATE OF PAID) RESPONSE

The following lists the segments and fields in a Claim Billing or Claim Rebill response (Paid or Duplicate of Paid) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i>
This Segment is situational	X	Segment sent if required for clarification

	Response Message Segment Segment Identification (111-AM) = "20"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	MESSAGE	Text Message	RW	Required if text is needed for clarification or detail.

Response Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

	Response Insurance Segment Segment Identification (111-AM) = "25"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
301-C1	GROUP ID		R	Used to identify the group number used in claim adjudication.
524-FO	PLAN ID		R	Used to identify the actual plan ID that was used in claim adjudication.

<b>Response Status Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i></b>
This Segment is always sent	X	

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
503-F3	AUTHORIZATION NUMBER	17-digit TCN	R	
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.

<b>Response Claim Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i></b>
This Segment is always sent	X	

	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

<b>Response Pricing Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i></b>
This Segment is always sent	X	

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID		R	
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		R	Populated with zeros

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.
5Ø9-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		RW	Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø).
514-FE	REMAINING BENEFIT AMOUNT		R	Populated with zeros.
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		R	Populated with zeros.
518-FI	AMOUNT OF COPAY		R	Patient Copay
52Ø-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		R	Populated with zeros.

<b>Response DUR/PPS Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)</b> If Situational, <i>Payer Situation</i>
This Segment is situational	X	Sent to provide information about DUR conflicts

	<b>Response DUR/PPS Segment Segment Identification (111-AM) = "24"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	Required if Reason For Service Code (439-E4) is used.

	<b>Response DUR/PPS Segment Segment Identification (111-AM) = "24"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
439-E4	REASON FOR SERVICE CODE		RW	Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE		RW	Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR		RW	Required if needed to supply additional information for the utilization conflict.
530-FU	PREVIOUS DATE OF FILL	CCYYMMDD	RW	Required if needed to supply additional information for the utilization conflict.
531-FV	QUANTITY OF PREVIOUS FILL		RW	Required if needed to supply additional information for the utilization conflict.
532-FW	DATABASE INDICATOR	1 = First DataBank – a drug database company	RW	Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR		RW	Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE		RW	Required if needed to supply additional information for the utilization conflict.

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

CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is situational	X	Segment sent if required for reject clarification

	Response Message Segment Segment Identification (111-AM) = "20"			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	MESSAGE	Text Message	RW	Required if text is needed for clarification or detail.

Response Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational		

	Response Insurance Segment Segment Identification (111-AM) = "25"			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø1-C1	GROUP ID		R	Used to identify the actual group ID used during adjudication.
524-FO	PLAN ID		R	Used to identify the actual plan ID used during adjudication.

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER	17-digit TCN	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR			Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Required if Additional Message Information (526-FQ) is used.

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Billing/Claim Rebill Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.

<b>Response Claim Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Rejected</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Billing/Claim Rebill Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is situational	X	

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE		RW	Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE		RW	Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR		RW	Required if needed to supply additional information for the utilization conflict.
530-FU	PREVIOUS DATE OF FILL	CCYYMMDD	RW	Required if needed to supply additional information for the utilization conflict.
531-FV	QUANTITY OF PREVIOUS FILL		RW	Required if needed to supply additional information for the utilization conflict.
532-FW	DATABASE INDICATOR	1 = First DataBank – a drug database company	RW	Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR		RW	Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE		RW	Required if needed to supply additional information for the utilization conflict.

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

CLAIM BILLING/CLAIM REBILL REJECTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

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

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, <i>Payer Situation</i>
This Segment is situational	X	Segment sent if required for reject clarification

	Response Message Segment Segment Identification (111-AM) = "2Ø"			Claim Billing/Claim Rebill Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	MESSAGE	Text Message	RW	Required if text is needed for clarification or detail.

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER	17-digit TCN	RW	Required if needed to identify the transaction.
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	Required if a repeating field is in error, to identify repeating field occurrence.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.

\*\* End of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template\*\*

**Reason for Service Codes (439-E4): DUR Conflict Codes**

Code	Meaning	Code	Meaning
AT	Additive Toxicity	LD	Low Dose Alert
CH	Call Help Desk	LR	Under Use Precaution
DA	Drug Allergy Alert	MC	Drug Disease Precaution
DC	Inferred Drug Disease Precaution	MN	Insufficient Duration Alert
DD	Drug-Drug Interaction	MX	Excessive Duration Alert
DF	Drug Food Interaction	OH	Alcohol Precaution
DI	Drug Incompatibility	PA	Drug Age Precaution
DL	Drug Lab Conflict	PG	Drug Pregnancy Alert
DS	Tobacco Use Precaution	PR	Prior Adverse Drug Reaction
ER	Over Use Conflict	SE	Side Effect Alert
HD	High Dose Alert	SX	Drug Gender Alert
IC	Iatrogenic Condition Alert	TD	Therapeutic Duplication
ID	Ingredient Duplication		

**Professional Service Codes (Valid Values for 440-E5)**

Code	Meaning	Code	Meaning
MA	Medication Administration – use for Vaccine Administration	PØ	Patient Consulted - patient interaction
MØ	Prescriber Consulted - MD Interface	RØ	Pharmacist Consulted Other Source - Pharmacist reviewed

**Result of Service Codes (Valid Values for 441-E6)**

Code	Meaning	Code	Meaning
1A	Filled As Is – False Positive	1F	Filled – Different Quantity
1B	Filled Prescription As Is	1G	Filled after prescriber approval
1C	Filled With Different Dose	2A	Not Filled
1D	Filled With Different Directions	2B	Not Filled – Directions Clarified

## NCPDP Version D.0 Claim Reversal Template

### Request Claim Reversal Payer Sheet Template

**\*\* Start of Request Claim Reversal (B2) Payer Sheet Template\*\***

#### FIELD LEGEND FOR COLUMNS

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

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	unlimited

#### CLAIM REVERSAL TRANSACTION

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

Transaction Header Segment Questions	Check	Claim Reversal <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used	X	

Transaction Header Segment		Claim Reversal		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
101-A1	BIN NUMBER	610084	M	
102-A2	VERSION/RELEASE NUMBER	D0	M	

Transaction Header Segment			Claim Reversal	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
103-A3	TRANSACTION CODE	B2	M	
104-A4	PROCESSOR CONTROL NUMBER	DRCOPROD = Production DRCOACCP = Test	M	
109-A9	TRANSACTION COUNT	DRCOPROD = Production DRCOACCP = Test	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = NPI	M	
201-B1	SERVICE PROVIDER ID	NPI Number	M	
401-D1	DATE OF SERVICE	CCYYMMDD	M	
110-AK	SOFTWARE VENDOR / CERTIFICATION ID	This will be provided by the provider's software vender	M	If no number is supplied, populate with zeros

Insurance Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent	X	

Insurance Segment Segment Identification (111-AM) = "04"			Claim Reversal	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	
301-C1	GROUP ID	Colorado	R	

Claim Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent	X	

Claim Segment Segment Identification (111-AM) = "Ø7"				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Number assigned by the pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code	M	
4Ø7-D7	PRODUCT/SERVICE ID	NDC Number	M	
4Ø3-D3	FILL NUMBER	Ø = Original Dispensing 1-99 = Number of refills	R	
3Ø8-C8	OTHER COVERAGE CODE	Ø=Not Specified 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	RW	Required when submitting a claim for a recipient who has other coverage.

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Reversal If Situational, <i>Payer Situation</i>
This Segment is situational	X	Required for COB claim reversals

	<b>Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"</b>			<b>Claim Reversal</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	

**\*\* End of Request Claim Reversal (B2) Payer Sheet Template\*\***

Document History for Pharmacy Billing Manual

<b>Date</b>	<b>Section</b>	<b>Version Number</b>	<b>Changes Made</b>	<b>Initials</b>
08/25/03	All	1.0	Reformatted / Updated Provider Manuals for	sz/dm

			HIPAA Compliance	
9/17/03	All	1.1	Added General paper and electronic section—added information provided by ACS/State Pharmacy committee to Billing section	sz
10/17/03	All	1.2	Updated and formatted for web.	jg
12/31/03	All	1.3	Updated and formatted for web.	jg
1/1/08	All	1.4	Updated and formatted information	ke
4/1/08	Timely Filing and Paper Claim Submission Requirements	1.5	Added PCF information	ke
5/24/08	Payer Sheet and PCF	1.6	Provider NPI requirement to Payer Sheet and PCF	ke
8/1/09	All	1.7	Mail Order and Web site references	ke
10/01/11	Payer Sheet	1.8	Added D.0 Payer Sheet	ss
12/23/11	PCF	1.9	Added updated PCF instructions	ss