



*"QUALITY IS IN EVERYTHING WE DO"*

# **NORTH CAROLINA MEDICAID HIPAA COMPANION GUIDE SPECIFICATION**

***NCPDP PHARMACEUTICAL DRUG CLAIMS VERSION D.Ø***

***VERSION 1.Ø  
AUGUST 2011***

# **NCPDP Version D.Ø Transaction Payer Sheet**

**Version 1.Ø**

**HP Enterprises Services bases the NCPDP D. Ø  
Companion Guide on the NCPDP Version 1.3 Payer Sheet Template**

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# 1. NCPDP VERSION D.0 CLAIM BILLING/CLAIM REBILL

## 1.1 REQUEST CLAIM BILLING/CLAIM REBILL PAYER SHEET

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

### GENERAL INFORMATION

Payer Name: North Carolina Medicaid		Date: August 22, 2011
Plan Name/Group Name: NC Medicaid		BIN: 601312
		PCN: Authorized submitting Value-Added-Network id assigned by HP
Processor: HP Enterprise Services		
Effective as of: January 1, 2012		NCPDP Telecommunication Standard Version/Release #: D.0
NCPDP Data Dictionary Version Date: October 2008		NCPDP External Code List Version Date: October 2008
Contact/Information Source: Other references such as Provider Manuals, Payer phone number, web site, etc.		
Certification Testing Window:		
Certification Contact Information:		
Provider Relations Help Desk Info: 1-800-688-6696 or 919-851-8888		
Other versions supported: N/A		

### OTHER TRANSACTIONS SUPPORTED

Transaction Code	Transaction Name
B2	Reversal

### FIELD LEGEND FOR COLUMNS

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

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

### CLAIM BILLING/CLAIM REBILL TRANSACTION

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

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued	X	

Field #	Transaction Header Segment	Value	Payer Usage	Claim Billing/Claim Rebill
	NCPDP Field Name			Payer Situation
101-A1	BIN NUMBER	601312	M	
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	

Transaction Header Segment			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
104-A4	PROCESSOR CONTROL NUMBER	Authorized submitting Value-Added-Network id assigned by HP	M	
109-A9	TRANSACTION COUNT	1 = One occurrence 2 = Two occurrences 3 = Three occurrences 4 = Four occurrences Maximum of one allowed for compound transactions	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 – National Provider ID (NPI)	M	
201-B1	SERVICE PROVIDER ID	10 digit NPI	M	
401-D1	DATE OF SERVICE	Format = CCYYMMDD	M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Authorized submitting software vendor id	M	

Insurance Segment Questions	Check	Claim Billing/Claim Rebill
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	NC Medicaid member ID as shown on card.	M	
360-2B	MEDICAID INDICATOR	NC = North Carolina	RW	<i>Imp Guide:</i> Required, if known, when patient has Medicaid coverage.  <i>Payer Requirement:</i> Same as Imp Guide

Patient Segment Questions	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	

Patient Segment Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill	
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
304-C4	DATE OF BIRTH		R	
305-C5	PATIENT GENDER CODE		R	
310-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	<i>Payer Requirement:</i> Same as Imp Guide
307-C7	PLACE OF SERVICE		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> NC Medicaid will source all data from the Patient Residence rather than from the new Place of Service.
335-2C	PREGNANCY INDICATOR	Blank=Not specified 1 = Not pregnant 2 = Pregnant	RW	<i>Imp Guide:</i> Required if pregnancy could result in different coverage, pricing, or patient financial responsibility.

	Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
				<i>Payer Requirement: Same as Imp guide.</i>
384-4X	PATIENT RESIDENCE	0 = Not Specified 1 = Home 2 = Skilled Nursing Facility 3 = Nursing Facility 4 = Assisted Living Facility 5 = Custodial Care Facility 6 = Group Home 9 = Intermediate Care Facility/Mentally Retarded 11 = Hospice 15 = Correctional Institution	RW	<i>Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility.</i>  <i>Payer Requirement: Same as Imp guide.</i>

Claim Segment Questions	Check	Claim Billing/Claim Rebill
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
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	NC Medicaid uses a 7 digit Rx number.	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	ØØ = Multi-ingredient prescription (compound) Ø3 = National Drug Code (NDC)	M	
4Ø7-D7	PRODUCT/SERVICE ID	NDC or Ø - when billing for a multi-ingredient prescription (compound)	M	
442-E7	QUANTITY DISPENSED	Quantity dispensed expressed in metric decimal units  Format = 9999999.999	R	
4Ø3-D3	FILL NUMBER	ØØ = Original Dispensing Ø1 - 9Ø = Refill number	R	
4Ø5-D5	DAYS SUPPLY	Estimated number of days the prescription will last.  3 digit numeric	R	
4Ø6-D6	COMPOUND CODE	1 = Not a Compound 2 = Compound	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Used to indicate prescriber's instructions regarding generic substitution Ø = No Product Selection Indicated	R	

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		1 = Substitution Not Allowed by Prescriber 5 = Substitution Allowed - Brand Drug Dispensed as a Generic 7 = Substitution Not Allowed-Brand Drug Mandated by Law 8 = Substitution Allowed-Generic Drug Not Available in Marketplace		
414-DE	DATE PRESCRIPTION WRITTEN	Format = CCYYMMDD	R	
419-DJ	PRESCRIPTION ORIGIN CODE	1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile	R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Submission Clarification Code (42Ø-DK) is used.  <i>Payer Requirement:</i> Same as Imp Guide.
42Ø-DK	SUBMISSION CLARIFICATION CODE	Ø2 = Other Override (Supply override) and PA/Non-Preferred Drug Override Ø3 = Vacation Supply Ø4 = Lost Prescription Ø5 = Therapy Change	RW	<i>Imp Guide:</i> Required if clarification is needed and value submitted is greater than zero (Ø).  Occurs the number of times identified in Submission Clarification Code Count (354-NX).  <i>Payer Requirement:</i> Same as Imp Guide.
3Ø8-C8	OTHER COVERAGE CODE	ØØ = Not Specified by patient Ø1 = No other coverage identified Ø2 = Other coverage exists - payment collected Ø3 = Other coverage billed – claim not covered Ø4 = Other coverage exists - payment not collected	RW	<i>Imp Guide:</i> Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers.  Required for Coordination of Benefits.  <i>Payer Requirement:</i> Same as Imp Guide
429-DT	SPECIAL PACKAGING INDICATOR	Ø = Not Specified 1 = Not Unit Dose 2 = Manufacturer Unit Dose 3 = Pharmacy Unit Dose 4 = Custom Packaging 5 = Multi-drug compliance packaging	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> Same as Imp Guide
418-DI	LEVEL OF SERVICE	Ø = Not Specified 1 = Patient consultation 2 = Home delivery 3 = Emergency	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.

Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		4 = 24 hour service 5 = Patient consultation regarding generic product selection		<i>Payer Requirement: Same as Imp Guide</i>
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 and/or. 5 = Exemption from RX. 6 = Family Planning Indicator. 8 = Payer Defined Exemption. 9 = Emergency Preparedness	RW	<i>Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility.</i>  <i>Payer Requirement: Same as Imp Guide</i>
343-HD	DISPENSING STATUS	Blank = Not Specified P=Partial Fill C=Completion of Partial Fill		<i>Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility.</i>  <i>Payer Requirement: NC Medicaid does not support partial/completion-of-partial fills.</i>

Pricing Segment Questions	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	

Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
433-DX	PATIENT PAID AMOUNT SUBMITTED		RW	<i>Imp Guide: Required if this field could result in different coverage, pricing, or patient financial</i>  <i>Payer Requirement: Same as Imp Guide</i>
426-DQ	USUAL AND CUSTOMARY CHARGE	Amount charged cash customers for the prescription.	R	
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION	Values supported by NCPDP D.Ø	RW	<i>Imp Guide: Required if needed for receiver claim adjudication.</i>  <i>Payer Requirement: NC Medicaid will not be using this field at this time.</i>

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = NPI	R	
411-DB	PRESCRIBER ID	1Ø digit NPI	R	

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 1 - Other Payer Amount Paid Repetitions Only	X	

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill Scenario 1 - Other Payer Amount Paid Repetitions Only
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE	Blank = Not Specified Ø1 = Primary - First Ø2 = Secondary - Second Ø3 = Tertiary - Third Ø4 = Quaternary - Fourth Ø5 = Quinary - Fifth Ø6 = Senary - Sixth Ø7 = Septenary - Seventh Ø8 = Octonary - Eighth Ø9 = Nonary - Ninth	M	
339-6C	OTHER PAYER ID QUALIFIER	Ø1 = National Payer Id Blank = Not Specified Ø2 = Health Industry Number (HIN) Ø3 = Bank Information Number (BIN) Ø4 = National Association of Insurance Commissioners (NAIC) Ø5 = Medicare Carrier Number 99 = Other	RW	<i>Imp Guide:</i> Required if Other Payer ID (34Ø-7C) is used.  <i>Payer Requirement:</i> Same as Imp Guide
34Ø-7C	OTHER PAYER ID		RW	<i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication.  <i>Payer Requirement:</i> Same as Imp Guide
443-E8	OTHER PAYER DATE		RW	<i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Scenario 1 - Other Payer Amount Paid Repetitions Only  <i>Payer Requirement: Same as Imp Guide</i>
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used.  <i>Payer Requirement: Same as Imp Guide</i>
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Supports all D.Ø values	RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used.  <i>Payer Requirement: Same as Imp Guide</i>
431-DV	OTHER PAYER AMOUNT PAID		RW	<i>Imp Guide:</i> Required if other payer has approved payment for some/all of the billing.  Zero (Ø) is a valid value.  Not used for patient financial responsibility only billing.  Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted.  <i>Payer Requirement: Same as Imp Guide</i>
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used.  <i>Payer Requirement: Same as Imp Guide</i>
472-6E	OTHER PAYER REJECT CODE		RW	<i>Imp Guide:</i> 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).  <i>Payer Requirement: Same as Imp Guide</i>

DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is situational	X	Required if overriding DUR alert information

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	<i>Imp Guide:</i> Required if DUR/PPS Segment is used.  <i>Payer Requirement: Same as Imp Guide</i>
439-E4	REASON FOR SERVICE CODE	DC = Drug-Disease DD = Drug-Drug Interaction ER = Overuse	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		HD = High Dose LD = Low Dose LR= Underuse TD= Therapeutic		drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement:</i> Required if 473-7E is used.
44Ø-E5	PROFESSIONAL SERVICE CODE	Values supported by NCPDP D.Ø	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement :</i> Required if 473-7E is used.
441-E6	RESULT OF SERVICE CODE	Values supported by NCPDP D.Ø	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement:</i> Required if 473-7E is used.

Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is situational	X	Required when Compound Code (406-D6) = 2 (compound)

Compound Segment Segment Identification (111-AM) = "1Ø"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	Values supported by NCPDP D.Ø	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	Values supported by NCPDP D.Ø	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3 = National Drug Code (NDC)	M	
489-TE	COMPOUND PRODUCT ID	11 digit NDC	M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		M	
49Ø-UE	COMPOUND INGREDIENT BASIS OF		O	<i>Imp Guide:</i> Required if needed for

Compound Segment Segment Identification (111-AM) = "10"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
	COST DETERMINATION			receiver claim determination when multiple products are billed.  <i>Payer Requirement:</i> NC Medicaid will not be using this field at this time.

Clinical Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is situational	X	Required when NC Medicaid requires the diagnosis code to qualify the claim

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	<i>Imp Guide:</i> Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.  <i>Payer Requirement:</i> Same as Imp Guide.
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1 = International Classification of Diseases (ICD9)	RW	<i>Imp Guide:</i> Required if Diagnosis Code (424-DO) is used.  <i>Payer Requirement:</i> NC Medicaid uses value 'Ø1' - International Classification of Diseases (ICD9)
424-DO	DIAGNOSIS CODE		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  <i>Payer Requirement:</i> NC Medicaid will process only one occurrence

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

## 1.2 RESPONSE CLAIM BILLING/CLAIM REBILL PAYER SHEET

### 1.2.1 CLAIM BILLING/CLAIM REBILL ACCEPTED/PAID (OR DUPLICATE OF PAID) RESPONSE

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

#### GENERAL INFORMATION

Payer Name: North Carolina Medicaid	Date: <b>Date</b>	
Plan Name/Group Name: NC Medicaid	BIN: 6Ø1312	PCN: Authorized submitting Value-Added-Network id assigned by HP

#### 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)
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) Payer Situation
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) Payer Situation
5Ø4-F4	MESSAGE			<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	P = Paid D = Duplicate of Paid	M	
5Ø3-F3	AUTHORIZATION NUMBER	15 Character Internal Control Number (ICN)	R	
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> NC Medicaid will return up to 9.

	<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>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	<p>Ø1 = Used for first line of free form text with no pre-defined structure.</p> <p>Ø2 = Used for second line of free form text with no pre-defined structure.</p> <p>Ø3 = Used for third line of free form text with no pre-defined structure.</p> <p>Ø4 = Used for fourth line of free form text with no pre-defined structure.</p> <p>Ø5 = Used for fifth line of free form text with no pre-defined structure.</p> <p>Ø6 = Used for sixth line of free form text with no pre-defined structure.</p> <p>Ø7 = Used for seventh line of free form text with no pre-defined structure.</p> <p>Ø8 = Used for eighth line of free form text with no pre-defined structure.</p> <p>Ø9 = Used for ninth line of free form text with no pre-defined structure.</p>	RW	<p><i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<p><i>Imp Guide:</i> Required when additional text is needed for clarification or detail.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<p><i>Imp Guide:</i> 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</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing NC Medicaid Service Billing supported only through 12/14/2011 using NCPDP version 5.1.	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	NC Medicaid uses a 7 digit Rx number.	M	

Response Pricing Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)
This Segment is always sent	X	

	Response Pricing Segment Segment Identification (111-AM) = "23"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
5Ø5-F5	PATIENT PAY AMOUNT		R	
5Ø6-F6	INGREDIENT COST PAID		R	
5Ø7-F7	DISPENSING FEE PAID		R	
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.  Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.  <i>Payer Requirement:</i> Same as Imp Guide.
5Ø9-F9	TOTAL AMOUNT PAID		R	
518-FI	AMOUNT OF COPAY		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Values supported by NCPDP D.Ø	RW	<i>Imp Guide:</i> Required if Ingredient Cost Paid (5 Ø6-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing.  <i>Payer Requirement:</i> NC Medicaid currently only uses value Ø5.

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i>
This Segment is situational	X	Present when DUR informational alerts have been identified

	Response DUR/PPS Segment Identification (111-AM) = "24"			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>
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used.  <i>Payer Requirement:</i> Same as Imp Guide
439-E4	REASON FOR SERVICE CODE	DC = Drug-Disease DD = Drug-Drug Interaction ER = Overuse HD = High Dose LD = Low Dose LR = Underuse TD = Therapeutic	RW	<i>Imp Guide:</i> Required if utilization conflict is detected.  <i>Payer Requirement:</i> Same as Imp Guide
528-FS	CLINICAL SIGNIFICANCE CODE	Blank = Not specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide
529-FT	OTHER PHARMACY INDICATOR	Ø = Not Specified 1 = Your Pharmacy 3 = Other Pharmacy	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide
53Ø-FU	PREVIOUS DATE OF FILL	Date prescription was previously filled.  Format=CCYYMMDD	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  Required if Quantity of Previous Fill (531-FV) is used.  <i>Payer Requirement:</i> Same as Imp Guide
531-FV	QUANTITY OF PREVIOUS FILL	Amount expressed in metric decimal units of the conflicting agent that was previously filled.  Format=9999999.999	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  Required if Previous Date Of Fill (53Ø-FU) is used.  <i>Payer Requirement:</i> Same as Imp Guide
532-FW	DATABASE INDICATOR	1 = First DataBank	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide
533-FX	OTHER PRESCRIBER INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			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>
544-FY	DUR FREE TEXT MESSAGE	Text that provides additional detail regarding a DUR conflict.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide

## 1.2.2 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
This Segment is always sent	X	

Field #	Response Transaction Header Segment	Value	Payer Usage	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>
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-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	Required when text is needed for clarification or detail.

	Response Message Segment Segment Identification (111-AM) = "2Ø"			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>
5Ø4-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide.

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected
This Segment is always sent	X	

Field #	Response Status Segment Segment Identification (111-AM) = "21"	Value	Payer Usage	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	

	<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>
5Ø3-F3	AUTHORIZATION NUMBER	15 Character Internal Control Number (ICN)	R	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	See National Council on Prescription Drug Programs (NCPDP) External Code List, Appendix A – Reject Codes	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence.  <i>Payer Requirement:</i> Same as Imp Guide.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> NC Medicaid will return up to 9.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Used for second line of free form text with no pre-defined structure. Ø3 = Used for third line of free form text with no pre-defined structure. Ø4 = Used for fourth line of free form text with no pre-defined structure. Ø5 = Used for fifth line of free form text with no pre-defined structure. Ø6 = Used for sixth line of free form text with no pre-defined structure. Ø7 = Used for seventh line of free form text with no pre-defined structure. Ø8 = Used for eighth line of free form text with no pre-defined structure. Ø9 = Used for ninth line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp Guide.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide.

Response Status Segment Segment Identification (111-AM) = "21"				Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<p><i>Imp Guide:</i> 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</p> <p>Payer Requirement: Same as Imp Guide</p>

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected
This Segment is always sent	X	

Response Claim Segment Segment Identification (111-AM) = "22"				Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing  NC Medicaid Service Billing supported only through 12/14/2011 using NCPDP version 5.1.	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	NC Medicaid uses a 7 digit Rx number.	M	

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is situational	X	This segment will be transmitted on a reject when a possible conflict is detected.

Response DUR/PPS Segment Segment Identification (111-AM) = "24"				Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	<p><i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used.</p> <p>Payer Requirement: Same as Imp Guide.</p>
439-E4	REASON FOR SERVICE CODE	DC = Drug-Disease DD = Drug-Drug Interaction ER = Overuse HD = High Dose LD = Low Dose LR= Underuse TD= Therapeutic	RW	<p><i>Imp Guide:</i> Required if utilization conflict is detected.</p> <p>Payer Requirement: Same as Imp Guide.</p>

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill Accepted/Rejected
528-FS	CLINICAL SIGNIFICANCE CODE	Blank = Not specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide
529-FT	OTHER PHARMACY INDICATOR	Ø = Not Specified 1 = Your Pharmacy 3 = Other Pharmacy	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide
53Ø-FU	PREVIOUS DATE OF FILL	Date prescription was previously filled.  Format=CCYYMMDD	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  Required if Quantity of Previous Fill (531-FV) is used.  <i>Payer Requirement:</i> Same as Imp Guide
531-FV	QUANTITY OF PREVIOUS FILL	Amount expressed in metric decimal units of the conflicting agent that was previously filled.  Format=9999999.999	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  Required if Previous Date Of Fill (53Ø-FU) is used.  <i>Payer Requirement:</i> Same as Imp Guide
532-FW	DATABASE INDICATOR	1 = First DataBank	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide
533-FX	OTHER PRESCRIBER INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide.
544-FY	DUR FREE TEXT MESSAGE	Text that provides additional detail regarding a DUR conflict.	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide.

### 1.2.3 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
This Segment is always sent	X	

Field #	Response Transaction Header Segment	Value	Payer Usage	Claim Billing/Claim Rebill Rejected/Rejected
				Payer Situation
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected
This Segment is situational	X	If Situational, <i>Payer Situation</i> Will be returned on rejected claims when the error is at transmission-level.

Field #	Response Message Segment Segment Identification (111-AM) = "2Ø"	Value	Payer Usage	Claim Billing/Claim Rebill Rejected/Rejected
				Payer Situation
5Ø4-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide.

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected
This Segment is always sent	X	

Field #	Response Status Segment Segment Identification (111-AM) = "21"	Value	Payer Usage	Claim Billing/Claim Rebill Rejected/Rejected
				Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER	15 Character Internal Control Number (ICN)	R	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	See National Council on Prescription Drug Programs (NCPDP) External Code List, Appendix A – Reject Codes	R	

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Billing/Claim Rebill Rejected/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence.  <i>Payer Requirement:</i> Same as Imp Guide.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> NC Medicaid will return up to 9.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Used for second line of free form text with no pre-defined structure. Ø3 = Used for third line of free form text with no pre-defined structure. Ø4 = Used for fourth line of free form text with no pre-defined structure. Ø5 = Used for fifth line of free form text with no pre-defined structure. Ø6 = Used for sixth line of free form text with no pre-defined structure. Ø7 = Used for seventh line of free form text with no pre-defined structure. Ø8 = Used for eighth line of free form text with no pre-defined structure. Ø9 = Used for ninth line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp Guide.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> 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  <i>Payer Requirement:</i> Same as Imp Guide

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

## 2. NCPDP VERSION D.0 CLAIM REVERSAL

### 2.1 REQUEST CLAIM REVERSAL PAYER SHEET

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

#### GENERAL INFORMATION

Payer Name: North Carolina Medicaid	Date: <span style="color: red;">Date</span>	
Plan Name/Group Name: NC Medicaid	BIN: 601312	PCN: Authorized submitting Value-Added-Network id assigned by HP

#### 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
NOT USED	<b>NA</b>	The Field is not used for the Segment in the designated Transaction.	No

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	365 days

#### 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
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued	X	

Field #	Transaction Header Segment	Value	Payer Usage	Claim Reversal
	NCPDP Field Name			Payer Situation
101-A1	BIN NUMBER	601312	M	
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	
104-A4	PROCESSOR CONTROL NUMBER	Authorized submitting Value-Added-Network id assigned by HP	M	
109-A9	TRANSACTION COUNT	01 – One occurrence	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 – National Provider Identifier (NPI)	M	
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	

Transaction Header Segment			Claim Reversal	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Authorized submitting software vendor id	M	

Insurance Segment Questions	Check	Claim Reversal
This Segment is always sent	X	

Insurance Segment Segment Identification (111-AM) = "Ø4"			Claim Reversal	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø2-C2	CARDHOLDER ID	Member's ID as shown on card.	M	

Claim Segment Questions	Check	Claim Reversal
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  NC Medicaid Service Billing supported only through 12/14/2011 using NCPDP version 5.1.	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	NC Medicaid uses a 7 digit Rx number.	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	ØØ = Multi-ingredient prescription (compound) Ø3 = NDC	M	
4Ø7-D7	PRODUCT/SERVICE ID	Valid NDC or Ø - when billing for a multi-ingredient prescription (compound)	M	

## 2.2 RESPONSE CLAIM REVERSAL PAYER SHEET TEMPLATE

### 2.2.1 CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

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

#### GENERAL INFORMATION

Payer Name: North Carolina Medicaid	Date:	
Plan Name/Group Name: NC Medicaid	BIN: 6Ø1312	PCN: Authorized submitting Value-Added-Network id assigned by HP

**CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE**

The following lists the segments and fields in a Claim Reversal response (Approved) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Response Transaction Header Segment Questions	Check	Claim Reversal – Accepted/Approved
This Segment is always sent	X	

Field #	Response Transaction Header Segment	Value	Payer Usage	Claim Reversal – Accepted/Approved
	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Header Segment Questions	Check	Claim Reversal – Accepted/Approved
This Segment is always sent	X	

Field #	Response Message Segment Identification (111-AM) = "2Ø"	Value	Payer Usage	Claim Reversal – Accepted/Approved
	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
5Ø4-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide.

Response Status Segment Questions	Check	Claim Reversal – Accepted/Approved
This Segment is always sent	X	

Field #	Response Status Segment Identification (111-AM) = "21"	Value	Payer Usage	Claim Reversal – Accepted/Approved
	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	
5Ø3-F3	AUTHORIZATION NUMBER	15 Character Internal Control Number (ICN)	R	
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> NC Medicaid will return up to 9.

Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Used for second line of free form text with no pre-defined structure. Ø3 = Used for third line of free form text with no pre-defined structure. Ø4 = Used for fourth line of free form text with no pre-defined structure. Ø5 = Used for fifth line of free form text with no pre-defined structure. Ø6 = Used for sixth line of free form text with no pre-defined structure. Ø7 = Used for seventh line of free form text with no pre-defined structure. Ø8 = Used for eighth line of free form text with no pre-defined structure. Ø9 = Used for ninth line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp Guide.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> 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  <i>Payer Requirement:</i> Same as Imp Guide

Response Claim Segment Questions	Check	Claim Reversal – Accepted/Approved
This Segment is always sent	X	

Response Claim Segment Segment Identification (111-AM) = "22"				Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Reversal – Accepted/Approved</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  NC Medicaid Service Billing supported only through 12/14/2011 using NCPDP version 5.1.	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	NC Medicaid uses a 7 digit Rx number.	M	

## 2.2.2 CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

### CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

<b>Response Transaction Header Segment Questions</b>	<b>Check</b>	<b>Claim Reversal - Accepted/Rejected</b>
This Segment is always sent	X	

	<b>Response Transaction Header Segment</b>			<b>Claim Reversal – Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

<b>Response Message Segment Questions</b>	<b>Check</b>	<b>Claim Reversal - Accepted/Rejected</b>
This Segment is always sent	X	

	<b>Response Message Segment Segment Identification (111-AM) = "2Ø"</b>			<b>Claim Reversal – Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
5Ø4-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide.

<b>Response Status Segment Questions</b>	<b>Check</b>	<b>Claim Reversal - Accepted/Rejected</b>
This Segment is always sent	X	

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Reversal – Accepted/Rejected</b>
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Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER	15 Character Internal Control Number (ICN)	R	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	See National Council on Prescription Drug Programs (NCPDP) External Code List, Appendix A – Reject Codes	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence.  <i>Payer Requirement:</i> Same as Imp Guide.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> NC Medicaid will return up to 9.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Used for second line of free form text with no pre-defined structure. Ø3 = Used for third line of free form text with no pre-defined structure. Ø4 = Used for fourth line of free form text with no pre-defined structure. Ø5 = Used for fifth line of free form text with no pre-defined structure. Ø6 = Used for sixth line of free form text with no pre-defined structure. Ø7 = Used for seventh line of free form text with no pre-defined structure. Ø8 = Used for eighth line of free form text with no pre-defined structure. Ø9 = Used for ninth line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp Guide.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide.

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Reversal – Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current  Payer Requirement: Same as Imp Guide

<b>Response Claim Segment Questions</b>	<b>Check</b>	<b>Claim Reversal - Accepted/Rejected</b>
This Segment is always sent	X	

	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Reversal – 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 = Rx Billing  NC Medicaid Service Billing supported only through 12/14/2011 using NCPDP version 5.1.	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	NC Medicaid uses a 7 digit Rx number.	M	

## 2.2.3 CLAIM REVERSAL REJECTED/REJECTED RESPONSE

### CLAIM REVERSAL REJECTED/REJECTED RESPONSE

<b>Response Transaction Header Segment Questions</b>	<b>Check</b>	<b>Claim Reversal - Rejected/Rejected</b>
This Segment is always sent	X	

	<b>Response Transaction Header Segment</b>			<b>Claim Reversal – Rejected/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	R= Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Reversal – Rejected/Rejected
This Segment is always sent	X	

	Response Message Segment Segment Identification (111-AM) = "2Ø"			Claim Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
5Ø4-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .

Response Status Segment Questions	Check	Claim Reversal - Rejected/Rejected
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER	15 Character Internal Control Number (ICN)	R	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	See National Council on Prescription Drug Programs (NCPDP) External Code List, Appendix A – Reject Codes	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence.  <i>Payer Requirement:</i> Same as <i>Imp Guide</i> .
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> NC Medicaid will return up to 9.

Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Used for second line of free form text with no pre-defined structure. Ø3 = Used for third line of free form text with no pre-defined structure. Ø4 = Used for fourth line of free form text with no pre-defined structure. Ø5 = Used for fifth line of free form text with no pre-defined structure. Ø6 = Used for sixth line of free form text with no pre-defined structure. Ø7 = Used for seventh line of free form text with no pre-defined structure. Ø8 = Used for eighth line of free form text with no pre-defined structure. Ø9 = Used for ninth line of free form text with no pre-defined structure.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp Guide.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> 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  <i>Payer Requirement:</i> Same as Imp Guide

**\*\* End of Claim Reversal (B2) Response Payer Sheet \*\***

## Document Change History

Project Information			
<b>Project Name:</b> NCPDP D.0 Implementation			
<b>Status:</b> Final (Version number and date are used for configuration control of this deliverable)			

Version	Issue Date	Created By	Comments/Reason
1.0		Monica Barkley	Original document