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NCPDP Pharmaceutical Drug Claims Version D.0 Companion Guide

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CSRA

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HEALTH AND HUMAN SERVICES

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1. Introduction

1.1 BACKGROUND

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carry provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The National Council for Prescription Drug Programs (NCPDP) is a non-profit organization formed in 1976. It is dedicated to the development and dissemination of voluntary consensus standards that are necessary to transfer information that is used to administer the prescription drug benefit program.

Refer to the NCPDP Telecommunication Version D documents *Telecommunication Standard Implementation Guide Version D.Ø, Data Dictionary, External Code List, and Telecommunication Version D Questions, Answers and Editorial Updates* for more detailed information on field values and segments.

The following information is intended to serve only as a Companion Guide to the aforementioned NCPDP Telecommunications Standard Version D.0 Documents. The use of this Companion Guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This Companion Guide supplements, but does not contradict any requirements in the NCPDP Telecommunications Standard Version D.0 Implementation Guide and related documents.

To request a copy of the NCPDP Standard Formats or for more information contact the National Council for Prescription Drug Programs, Inc. at www.ncpdp.org. The contact information is as follows:

National Council for Prescription Drug Programs
924Ø East Raintree Drive
Scottsdale, AZ 8526Ø
Phone: (48Ø) 477-1ØØØ
Fax: (48Ø) 767-1Ø42

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2Ø1Ø NCPDP

1.2 COMPANION GUIDE DISCLAIMER

The North Carolina Department of Health and Human Services (NCDHHS) has provided this Payer Sheet Companion Guide for the NCPDP transactions to assist Providers, Clearinghouses, and all Covered Entities in preparing HIPAA compliant transactions. This document was prepared using the *Telecommunication Standard Implementation Guide Version D.Ø, Data Dictionary, External Code List and Telecommunication Version D Questions, Answers and Editorial Updates.*

NCDHHS does not offer individual training to assist Providers in the use of the NCPDP transactions.

The information provided herein is believed to be true and correct based on the aforementioned NCPDP Telecommunication Standard Version D.0 Implementation Guide and the related documents. The HIPAA regulations are continuing to evolve. Therefore, NCTracks makes no guarantee, expressed or implied, as to the accuracy of the information provided herein. Furthermore, this is a living document and the information provided herein is subject to change as NCDHHS policy changes or as HIPAA legislation is updated or revised.

1.3 NCTRACKS NOTE

Under HIPAA the National Council for Prescription Drug Programs *Telecommunication Standard Implementation Guide Version D.Ø*, *Data Dictionary, and External Code List*, has been adopted by Health and Human Services as standard transactions for Retail Pharmacy.

This Companion Guide, which is provided by the NCDHHS, outlines the required format for the NCTracks Retail Pharmacy transactions. It is important that Providers study the Companion Guide and become familiar with the data that will be expected by NCTracks in transmission of a Pharmacy Transaction.

This Companion Guide does not modify the standards; rather, it puts forth the subset of information from the NCPDP *Telecommunications Standard Version D.0 Implementation Guide, Data Dictionary, External Code List, and Version D.0 Editorial Updates* that will be required for processing transactions.

It is important that providers use this Companion Guide as a supplement to the NCPDP Standard D.0 documents. Within the IG, there are data elements, which have many different qualifiers available for use. Each qualifier identifies a different piece of information. This document omits code qualifiers that are not necessary for NCTracks processing. Although not all available codes are listed in this document, NCDHHS will accept any codes named or listed in the NCPDP Data Dictionary and External Code List. When necessary, NCTracks notes are included under “Payer Situation” to describe the NCDHHS specific requirements.

Although not all IG items are listed in the Companion Guide, NCTracks will accept and capture the data from all transactions that comply with the HIPAA IG. Providers are required to use the NCPDP Telecommunication Standard Implementation Guide Version D.Ø, the Data Dictionary, and the External Code List (ECL), to understand the positioning, format and usage of the transaction and data elements.

Providers with questions regarding HIPAA compliance billing please call CSRA’s support unit at 1-866-844-1113.

Pharmacy Providers can acquire the aforementioned NCPDP documents from www.ncpdp.org.

1.4 INTENDED USE

This guide is intended to provide guidelines to software vendors, switching companies and pharmacy providers as they implement the NCPDP D.0 Standard. The information included in this companion guide contains the D.0 transactions supported by NCDHHS.

1.5 SYSTEM AVAILABILITY

The NCTracks NCPDP transaction submission system is available to providers 24 hours a day, seven days a week.

2. NCPDP D.0 Transactions Supported by NCDHHS

Transaction Code	Transaction Name
E1	Eligibility
B1	Claim Billing
B2	Claim Reversal
B3	Claim Rebill
N1	Information Reporting
N2	Information Reporting Reversal
N3	Information Reporting Rebill

NCDHHS does not support the following transactions: C1, C2, C3, D1, P1, P2, P3, P4, S1, S2, and S3.

NCDHHS does not support/require the following segments: Coupon and Workers' Comp.

Transaction Format Information
Please refer to the NCPDP D.0 Implementation Guide, Data Dictionary, and External Code List to understand the positioning, format, and use of the data elements.

3. Eligibility Verification

3.1 ELIGIBILITY VERIFICATION REQUEST

3.1.1 Eligibility Verification Request (Payer Sheet)

**** Start of Request Eligibility Verification Segments (E1) Payer Sheet ****

GENERAL INFORMATION

Payer Name: North Carolina Department of Health and Human Services (NCDHHS)	Date: 11/07/2011	
Plan Name/Group Name: NCTracks	BIN: 610242	PCN: NCTracks ID
Processor: CSRA		
Effective as of: 07/21/2011	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: 07/2007	NCPDP External Code List Version Date: 09/2010	
Contact/Information Source: Provider Manuals available at www.nctracks.com/content/public/providers/provider-manuals.html General Website: www.nctracks.nc.gov		
Provider Relations Help Desk Info: 1-866-844-1113		
Other versions supported:		

OTHER TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal
B3	Claim Rebill
N1	Information Reporting
N2	Information Reporting Reversal
N3	Information Reporting Rebill

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 Eligibility Verification Request transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

ELIGIBILITY VERIFICATION REQUEST TRANSACTION

The following lists the segments and fields in an Eligibility Verification Request Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Transaction Header Segment Questions	Check	Eligibility Verification Request If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Eligibility Verification Request
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø1-A1	BIN NUMBER	610242	M	BIN for NCTracks
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	E1	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	1 = One occurrence	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider ID	M	
2Ø1-B1	SERVICE PROVIDER ID		M	10-digit NPI
4Ø1-D1	DATE OF SERVICE		M	Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill

Insurance Segment Questions	Check	Eligibility Verification Request If Situational, *Payer Situation*
This Segment is always sent	X	

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Eligibility Verification Request
3Ø2-C2	CARDHOLDER ID	NC Medicaid member ID as shown on card	M	10-digit recipient NC Medicaid Identification (MID) Number.

Patient Segment Questions	Check	Eligibility Verification Request If Situational, *Payer Situation*
This Segment is always sent	X	
This Segment is situational		

	Patient Segment Segment Identification (111-AM) = "Ø1"			Eligibility Verification Request
Field	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
331-CX	PATIENT ID QUALIFIER	99	M	99 = Other (NCTracks Recipient Identification Number). Left justify and space fill.
332-CY	PATIENT ID		M	
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE	1 = Male 2 = Female	R	
31Ø-CA	PATIENT FIRST NAME		RW	*Imp Guide:* Required when the patient has a first name. *Payer Requirement:* As above.
311-CB	PATIENT LAST NAME		R	
3Ø7-C7	PLACE OF SERVICE		R	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility.

**** End of Request Eligibility Verification Request (E1) Payer Sheet ****

3.2 ELIGIBILITY VERIFICATION RESPONSE

**** Start of Eligibility Verification Response (E1) Payer Sheet ****

GENERAL INFORMATION

Payer Name: North Carolina Department of Health and Human Services (NCDHHS)	Date: 11/07/2011	
Plan Name/Group Name: NCTracks	BIN: 610242	PCN: NCTracks ID

3.2.1 Eligibility Verification Response (Transmission Accepted / Transaction Approved)

Response Transaction Header Segment Questions	Check	Eligibility Verification Response (Transmission Accepted/Transaction Approved) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Eligibility Verification Response (Transmission Accepted/Transaction Approved)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	E1	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	

	Response Transaction Header Segment			Eligibility Verification Response (Transmission Accepted/Transaction Approved)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
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	Eligibility Verification Response (Transmission Accepted/Transaction Approved) If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	*Provide general information when used for transmission-level messaging.*

	Response Message Segment Segment Identification (111-AM) = "2Ø"			Eligibility Verification Response (Transmission Accepted/Transaction Approved)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
5Ø4-F4	MESSAGE		RW	*Imp Guide:* Required if text is needed for clarification or detail. *Payer Requirement:* As above.

Response Status Segment Questions	Check	Eligibility Verification Response (Transmission Accepted/Transaction Approved) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Eligibility Verification Response (Transmission Accepted/Transaction Approved)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	

3.2.2 Eligibility Verification Response (Transmission Accepted / Transaction Rejected)

Response Transaction Header Segment Questions	Check	Eligibility Verification Response (Transmission Accepted/Transaction Rejected) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Eligibility Verification Response (Transmission Accepted/Transaction Rejected)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	E1	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 Status Segment Questions	Check	Eligibility Verification Response (Transmission Accepted/Transaction Rejected) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = “21”			Eligibility Verification Response (Transmission Accepted/Transaction Rejected)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
51Ø-FA	REJECT COUNT	Maximum count of 5	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.

3.2.3 Eligibility Verification Response (Transmission Rejected / Transaction Rejected)

Response Transaction Header Segment Questions	Check	Eligibility Verification Response Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Eligibility Verification Response Rejected/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	E1	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 Status Segment Questions	Check	Eligibility Verification Response Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = “21”			Eligibility Verification Response Rejected/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
51Ø-FA	REJECT COUNT	Maximum count of 5	R	
511-FB	REJECT CODE		R	NCDHHS will return 1 to 5 Reject codes.
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.

**** End of Response Eligibility Verification Response (E1) Payer Sheet ****

4. Claim Billing / Claim Rebill

4.1 CLAIM BILLING / CLAIM REBILL REQUEST

4.1.1 Claim Billing / Claim Rebill Request (Payer Sheet)

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

GENERAL INFORMATION

Payer Name: North Carolina Department of Health and Human Services (NCDHHS)	Date: 11/07/2011	
Plan Name/Group Name: NCTracks	BIN: 610242	PCN: NCTracks ID
Processor: CSRA		
Effective as of: 07/21/2011	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: 07/2007	NCPDP External Code List Version Date: 09/2010	
Contact/Information Source: Provider Manuals available at www.nctracks.com/content/public/providers/provider-manuals.html General Website www.nctracks.nc.gov		
Provider Relations Help Desk Info: MEVS Unit 1-866-844-1113		
Other versions supported:		

OTHER TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name
B2	Claim Reversal
E1	Eligibility Verification
N1	Information Reporting
N2	Information Reporting Reversal
N3	Information Reporting Rebill

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.Ø*.

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
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	610242	M	BIN for NCTracks
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	1 = One occurrence 2 = Two occurrences 3 = Three occurrences 4 = Four occurrences	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider ID	M	
2Ø1-B1	SERVICE PROVIDER ID		M	10-digit NPI
4Ø1-D1	DATE OF SERVICE		M	Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill

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

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Claim Billing/Claim Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
3Ø2-C2	CARDHOLDER ID		M	10-digit recipient NC Medicaid Identification (MID) Number.
312-CC	CARDHOLDER FIRST NAME		M	
313-CD	CARDHOLDER LAST NAME		M	

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

	Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing/Claim Rebill
Field	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
332-CY	PATIENT ID		R	10-digit recipient NC Medicaid Identification (MID) Number.
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE	1 = Male 2 = Female	R	
31Ø-CA	PATIENT FIRST NAME		RW	*Imp Guide:* Required when the patient has a first name. *Payer Requirement:* As above.
311-CB	PATIENT LAST NAME		R	
3Ø7-C7	PLACE OF SERVICE	All code set values supported CMS Maintained code set	R	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* NC DHHS will source all data from the Patient Residence rather than from the new Place of Service.
384-4X	PATIENT RESIDENCE	Ø = 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	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* As above.
335-2C	PREGNANCY INDICATOR	Blank = Not Specified 1 = Not pregnant 2 = Pregnant	RW	*Imp Guide:* Required if pregnancy could result in different coverage, pricing, or patient financial responsibility. Required if "required by law" as defined in the HIPAA final Privacy regulations section 164.5Ø1 definitions (45 CFR Parts 16Ø and 164 Standards for Privacy of Individually

	Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing/Claim Rebill
Field	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				Identifiable Health Information; Final Rule- Thursday, December 28, 2ØØØ, page 828Ø3 and following, and Wednesday, August 14, 2ØØ2, page 53267 and following.) *Payer Requirement:* Required when the member is known to be pregnant.

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
This payer supports partial fills		
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	*Imp Guide:* 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	The prescription number assigned by the pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = NDC	M	Ø1 = UPC – is not used for Division of Health Benefits (DHB) or Division of Public Health (DPH) claims at this time
4Ø7-D7	PRODUCT/SERVICE ID		M	If billing for a multi-ingredient prescription, Product/Service ID (4Ø7-D7) is zero. (Zero means "Ø".) NCDHHS requires an NDC code or 0 (zero).
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE		R	

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Ø = No Product Selection Indicated 1 = Substitute Not Allowed by Prescriber 5 = Sub Allowed-Brand Drug Dispensed as Generic 7 = Sub Not Allowed-Brand Drug Mandated by Law 8 = Sub Allowed-Generic Drug Not Avail. in Market 9 = Sub Allowed By Prescriber-Plan Requests Brand	R	NCDHHS requires one of the listed codes to process a claim.
414-DE	DATE PRESCRIPTION WRITTEN		R	Format CCYYMMDD
419-DJ	PRESCRIPTION ORIGIN CODE		R	*Imp Guide:* Required if necessary for plan benefit administration.
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3	RW	*Imp Guide:* Required if Submission Clarification Code (42Ø-DK) is used. *Payer Requirement:* As above.
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 1Ø = Meets Plan Limitations 11 = Certification on file 2Ø = 340B Provider	RW	*Imp Guide:* Required if clarification is needed and value submitted is greater than zero (Ø). *Payer Requirement:* Required if clarification is needed when value submitted is greater than zero (Ø). NCDHHS will process up to three occurrences of the codes listed.
3Ø8-C8	OTHER COVERAGE CODE	ØØ = Not Specified Ø1 = No Other Coverage Identified Ø2 = Other Coverage Exists – Payment Collected Ø3 = Other Coverage Exists – This Claim Not Covered Ø4 = Other Coverage Exists – Payment Not Collected	RW	*Imp Guide:* 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. *Payer Requirement:* Required when other insurance coverage exists.

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
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 Coinsurance 5 = Exemption from RX 6 = Family Planning Indicator 8 = Payer Defined Exemption 9 = Emergency Preparedness	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* Required when the claim requires Prior Authorization/Approval, or is co-pay exempt.
418-DI	LEVEL OF SERVICE		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility

Pricing Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
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	
426-DQ	USUAL AND CUSTOMARY CHARGE		R	*Imp Guide:* Required if needed per trading partner agreement. *Payer Requirement:* Required.
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION	ØØ = Not Specified Ø8 = 340B	RW	*Imp Guide:* Required if needed for receiver claim/encounter adjudication. *Payer Requirement:* Required if this field could result in different coverage, pricing, or patient financial responsibility.

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

	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	*Imp Guide:* Required if Prescriber ID (411-DB) is used. *Payer Requirement:* NCDHHS requires the NPI qualifier.
411-DB	PRESCRIBER ID	10-digit NPI	R	*Imp Guide:* Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* NCDHHS requires the NPI of the prescriber.

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc. claims.
Scenario 1 – Other Payer Amount Paid Repetitions Only	X	
Scenario 2 – Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
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.

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		RW	*Imp Guide:* Required if Other Payer ID (34Ø-7C) is used. *Payer Requirement:* Required when another payer has adjudicated this claim. NCDHHS recognizes the listed codes.
34Ø-7C	OTHER PAYER ID		RW	*Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication. *Payer Requirement:* Required when another payer has adjudicated this claim.
443-E8	OTHER PAYER DATE		RW	*Imp Guide:* 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	*Imp Guide:* Required if Other Payer Amount Paid Qualifier (342-HC) is used. *Payer Requirement:* Required when another payer has adjudicated this claim.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	All code set values supported	RW	*Imp Guide:* Required if Other Payer Amount Paid (431-DV) is used. *Payer Requirement:* Required when another payer has adjudicated this claim.
431-DV	OTHER PAYER AMOUNT PAID		RW	*Imp Guide:* Required if other payer has approved payment for some/all of the billing. 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. *Payer Requirement:* Required when

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				another payer has adjudicated this claim.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5	RW	*Imp Guide:* Required if Other Payer Reject Code (472-6E) is used. *Payer Requirement:*
472-6E	OTHER PAYER REJECT CODE		RW	*Imp Guide:* 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). *Payer Requirement:*
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25	RW	*Imp Guide:* Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. *Payer Requirement:*
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Accepted code set values: Ø1 = Deductible Amount Ø2 = Product /Selection / Brand Drug Amount Ø3 = Amount attributed to sales tax Ø4 = Amount reported from previous payer as Exceeding Periodic Benefit Maximum. Ø5 = Copay Amount Ø6 = Patient Pay Amount as reported by previous payer Ø7 = Coinsurance Amount. Ø8 = Product Selection/ Non-Preferred Formulary Selection Amount Ø9 = Health Plan Assistance Amount 1Ø= Provider Network Selection Amount 11 = Product/Selection/ Brand Non-Preferred Formulary Selection Amount 12 = Coverage Gap Amount 13 = Amount Attributed to Processor Fee	RW	*Imp Guide:* Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. *Payer Requirement:* Values qualified by accepted values Ø1, Ø5, or Ø7 will be summed as Other Payer Amounts. All other qualified values will be bypassed.

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	*Imp Guide:* Required if necessary for patient financial responsibility only billing. Required if necessary for state/ federal/regulatory agency programs. Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted. *Payer Requirement:* Required when reporting Deductible, Coinsurance, Co-pay, or Other Patient Responsibility amounts.

DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	

	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	*Imp Guide:* Required if DUR/PPS Segment is used. *Payer Requirement:* As above.
439-E4	REASON FOR SERVICE CODE	ER = DRUG OVERUSE TD = DRUG THERAPEUTIC DUPLICATION DD = DRUG-DRUG INTERACTION DC = DRUG-DISEASE CONTRAINDICATION LD = DRUG LOW DOSE HD = DRUG HIGH DOSE LR = DRUG UNDERUSE	RW	*Imp Guide:* 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. *Payer Requirement*: Required when sending a DUR override of a previously denied claim.

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
44Ø-E5	PROFESSIONAL SERVICE CODE	ØØ = NO INTERVENTION AS = PATIENT ASSESSMENT CC = COORDINATION OF CARE DE = DOSING EVAL/DETERMINATION DP = DOSAGE EVALUATED FE = FORMULARY ENFORCEMENT GP = GENERIC PRODUCT SELECTION M0 = PRESCRIBER CONSULTED MA = MEDICATION ADMINISTRATION MB = OVERRIDING BENEFIT MP = PATIENT WILL BE MONITORED MR = MEDICATION REVIEW PA = PREVIOUS PATIENT TOLERANCE PE = PATIENT EDUCATION/INSTRUCTION PH = PATIENT MEDICATION HISTORY PM = PATIENT MONITORING P0 = PATIENT CONSULTED PT = PERFORM LABORATORY TEST R0 = PHARMACIST CONSULTED OTH SOURCE RT = RECOMMEND LABORATORY TEST SC = SELF-CARE CONSULTATION SW = LITERATURE SEARCH/REVIEW TC = PAYER/PROCESSOR CONSULTED TH = THERAPEUTIC PRODUCT INTERCHANGE ZZ = OTHER ACKNOWLEDGEMENT	RW	*Imp Guide:* 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. *Payer Requirement:* Required when sending a DUR override of a previously denied claim.

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
441-E6	RESULT OF SERVICE CODE	ØØ = NOT SPECIFIED 1A = FILLED, FALSE POSITIVE 1B = FILLED PRESCRIPTION AS IS 1C = FILLED WITH DIFFERENT DOSAGE 1D = FILLED WITH DIFFERENT DIRECTIONS 1E = FILLED WITH DIFFERENT DRUG 1F = FILLED WITH DIFFERENT QUANTITY 1G = FILLED WITH PRESCRIBER APPROVAL 1H = BRAND TO GENERIC CHANGE 1J = RX TO OTC CHANGE 1K = FILLED WITH DIFFERENT DOSAGE 2A = PRESCRIPTION NOT FILLED 2B = NOT FILLED DIRECTIONS CLARIFIED 3A = RECOMMENDATION ACCEPTED 3B = RECOMMENDATION NOT ACCEPTED 3C = DISCONTINUED DRUG 3D = REGIMEN CHANGED 3E = THERAPY CHANGED 3F = THERAPY CHANGED COST INCREASED ACKNOWLEDGED 3G = DRUG THERAPY UNCHANGED 3H = FOLLOW UP REPORT 3J = PATIENT REFERRAL 3K = INSTRUCTIONS UNDERSTOOD 3M = COMPLIANCE AID PROVIDED 3N = MEDICATION	RW	*Imp Guide:* 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. *Payer Requirement:* Required when sending a DUR override of a previously denied claim.

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		ADMINISTERED All code set values supported.		

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

	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		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3 = NDC	M	NCDHHS expects NDCs to be reported.
489-TE	COMPOUND PRODUCT ID	11-digit NDC	M	NCDHHS will process NDCs on claim.
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		R	*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement:* Required.
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	ØØ = Not Specified Ø8 = 340B	RW	*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement:* Required if this field could result in different coverage, pricing, or patient financial responsibility.

Clinical Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when NC Medicaid requires diagnosis codes 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 3	RW	*Imp Guide:* Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. *Payer Requirement:* Same as Imp Guide.
492-WE	DIAGNOSIS CODE QUALIFIER	NCDHHS expects 'Ø1' = ICD9 coding 'Ø2' = ICD10 (Future use)	RW	*Imp Guide:* Required if Diagnosis Code (424-DO) is used. *Payer Requirement:* NC Medicaid uses value "Ø1" – International Classification of Diseases (ICD9).
424-DO	DIAGNOSIS CODE	ICD9 code identifying diagnosis of the patient	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs.

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

4.2 CLAIM BILLING / CLAIM REBILL RESPONSE

4.2.1 Claim Billing / Claim Rebill Response (Transmission Accepted –Transaction Paid/Captured (or Duplicate of Captured))

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

GENERAL INFORMATION

Payer Name: North Carolina Department of Health and Human Services (NCDHHS)	Date: 11/07/2011	
Plan Name/Group Name: NCTracks	BIN: 610242	PCN: NCTracks ID

Claim Billing/Claim Rebill captured (or Duplicate of captured) Response

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

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

	Response Transaction Header Segment			Claim Billing/Claim Rebill – Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**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 Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = “21”			Claim Billing/Claim Rebill – Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	P = Paid C = Captured D = Duplicate of Paid	M	NCDHHS will return ‘P’-Paid, ‘C’-Captured, ‘D’-Duplicate of Paid.
5Ø3-F3	AUTHORIZATION NUMBER		R	TCN is returned in this field on a Captured, Paid, or Rejected Response.

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Billing/Claim Rebill – Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	NCDHHS will return the Prescription/Service Reference Number submitted.

Response Pricing Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Pricing Segment Segment Identification (111-AM) = "23"			Claim Billing/Claim Rebill – Accepted / Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
5Ø5-F5	PATIENT PAY AMOUNT		R	NCDHHS will return the co-pay amount due. If the member is co-pay exempt, or has met the annual maximum, zeros will be returned.
5Ø6-F6	INGREDIENT COST PAID		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. *Payer Requirement:* NCDHHS will return the Ingredient Cost Paid With Paid response.
5Ø7-F7	DISPENSING FEE PAID		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. *Payer Requirement:* NCDHHS will return the Dispensing Fee Paid With Paid response.
518-FI	AMOUNT OF COPAY		R	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes copay as patient financial responsibility. *Payer Requirement:* NCDHHS will return the co-pay amount due.

	Response Pricing Segment Segment Identification (111-AM) = "23"			Claim Billing/Claim Rebill – Accepted / Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				If the member is co-pay exempt, or has met the annual maximum, zeros will be returned.
5Ø9-F9	TOTAL AMOUNT PAID		R	NCDHHS will return the Total Amount Paid With Paid response.

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	NCDHHS will provide this segment when the claim has DUR edit(s).

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill – Accepted/ Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported	RW	*Imp Guide:* Required if Reason For Service Code (439-E4) is used. *Payer Requirement:* When this segment is used, NCDHHS will populate this field.
439-E4	REASON FOR SERVICE CODE	ER = DRUG OVERUSE TD = DRUG THERAPEUTIC DUPLICATION DD = DRUG-DRUG INTERACTION DC = DRUG-DISEASE CONTRAINDICATION LD = DRUG LOW DOSE HD = DRUG HIGH DOSE LR = DRUG UNDERUSE PG = DRUG-PREGNANCY PA = DRUG-AGE ID = INGREDIENT DUPLICATION	RW	*Imp Guide:* Required if utilization conflict is detected. *Payer Requirement:* When this segment is used, NCDHHS will populate this field.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill – Accepted/ Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
528-FS	CLINICAL SIGNIFICANCE CODE	Blank = Not specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* When this segment is used, NCDHHS will populate this field.
529-FT	OTHER PHARMACY INDICATOR	Ø = Not Specified 1 = Your Pharmacy 3 = Other Pharmacy	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide
53Ø-FU	PREVIOUS DATE OF FILL	Previously filled date Format CCYYMMDD	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. *Payer Requirement:* When this segment is used, NCDHHS will populate this field, when applicable.
531-FV	QUANTITY OF PREVIOUS FILL	Quantity of the conflicting agent that was previously filled Format = 9999999.999 Implied Decimal Place	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used. *Payer Requirement:* When this segment is used, NCDHHS will populate this field, when applicable.
532-FW	DATABASE INDICATOR	1 First DataBank	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* When this segment is used, NCDHHS will populate this field. NCDHHS will return Value '1'. 1 = First Databank
533-FX	OTHER PRESCRIBER INDICATOR		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill – Accepted/ Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
544-FY	DUR FREE TEXT MESSAGE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* NCDHHS will provide information in this field when necessary.

4.2.2 Claim Billing / Claim Rebill Response (Transmission Accepted / Transaction Rejected)

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

	Response Transaction Header Segment			Claim Billing/Claim Rebill Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**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 Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	TCN is returned in this field on a Captured Paid or Rejected Response.

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
51Ø-FA	REJECT COUNT	Maximum count of 5	R	NCDHHS will return 1 to 5 on rejected claim.
511-FB	REJECT CODE		R	NCDHHS will return 1 to 5 Reject codes.
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, *Payer Situation*
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	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	NCDHHS will return the value received in the request transaction.

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	The segment is provided when a 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	*Imp Guide:* Required if Reason For Service Code (439-E4) is used. *Payer Requirement:* When this segment is used, NCDHHS will populate this field.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
439-E4	REASON FOR SERVICE CODE	ER = DRUG OVERUSE TD = DRUG THERAPEUTIC DUPLICATION DD = DRUG-DRUG INTERACTION DC = DRUG-DISEASE CONTRAINDICATION LD = DRUG LOW DOSE HD = DRUG HIGH DOSE LR = DRUG UNDERUSE PG = DRUG-PREGNANCY PA = DRUG-AGE ID = INGREDIENT DUPLICATION	RW	*Imp Guide:* Required if utilization conflict is detected. *Payer Requirement:* When this segment is used, NCDHHS will populate this field.
528-FS	CLINICAL SIGNIFICANCE CODE	Blank = Not specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* When this segment is used, NCDHHS will populate this field.
529-FT	OTHER PHARMACY INDICATOR	Ø = Not Specified 1 = Your Pharmacy 3 = Other Pharmacy	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide.
53Ø-FU	PREVIOUS DATE OF FILL	Previously filled date Format CCYYMMDD	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. *Payer Requirement:* When this segment is used, NCDHHS will populate this field, when applicable.
531-FV	QUANTITY OF PREVIOUS FILL	Quantity of the conflicting agent that was previously filled. Format = 9999999.999 Implied decimal place	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used. *Payer Requirement:* When this segment is used, NCDHHS will populate this field, when

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				applicable.
532-FW	DATABASE INDICATOR	1 First DataBank	RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* When this segment is used, NCDHHS will populate this field. NCDHHS will return Value "1". 1 = First Databank
533-FX	OTHER PRESCRIBER INDICATOR		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* Same as Imp Guide.
544-FY	DUR FREE TEXT MESSAGE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:* NCDHHS will provide information in this field when necessary.

4.2.3 Claim Billing / Claim Rebill Response (Transmission Rejected / Transaction Rejected)

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

	Response Transaction Header Segment			Claim Billing/Claim Rebill Rejected/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**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 Status Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Rejected/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	NCDHHS will return 1 to 5 Reject codes.
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	Imp Guide: Required if a repeating field is in error, to identify repeating field occurrence.

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

5. Claim Reversal

5.1 CLAIM REVERSAL REQUEST

5.1.1 Claim Reversal Request (Payer Sheet)

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

GENERAL INFORMATION

Payer Name: North Carolina Department of Health and Human Services (NCDHHS)	Date: 11/07/2011	
Plan Name/Group Name: NCTracks	BIN: 610242	PCN: NCTracks ID

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
NOT USED	NA	The Field is not used for the Segment in the designated Transaction. Not used are shaded for clarity for the Payer when creating the Template. For the actual Payer Template, not used fields must be deleted from the transaction (the row in the table removed).	No

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	1 year

Claim Reversal Transaction

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

Transaction Header Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Claim Reversal
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø1-A1	BIN NUMBER	All requests must send '610242'	M	NCDHHS requires '610242'
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	1 = One occurrence 2 = Two occurrences 3 = Three occurrences 4 = Four occurrences	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider ID	M	
2Ø1-B1	SERVICE PROVIDER ID		M	10-digit NPI
4Ø1-D1	DATE OF SERVICE		M	Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill

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	*Imp Guide:* For Transaction Code of "B2", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	The prescription number assigned by the pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = NDC	M	If billing for a multi-ingredient prescription, Product/Service ID Qualifier (436-E1) is zero ("ØØ"). NCDHHS requires one of these codes.
4Ø7-D7	PRODUCT/SERVICE ID		M	If billing for a multi-ingredient prescription, Product/Service ID (4Ø7-D7) is zero. (Zero means "Ø".) NCDHHS requires an NDC code, an HCPCS Code, or 0 (zero).

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

5.2 CLAIM REVERSAL RESPONSE

5.2.1 Claims Reversal Accepted/Approved Response (Captured or Duplicate of Captured)

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

GENERAL INFORMATION

Payer Name: North Carolina Department of Health and Human Services (NCDHHS)	Date: 11/07/2011	
Plan Name/Group Name: NCTracks	BIN: 610242	PCN: NCTracks ID

Claim Reversal captured (or Duplicate of captured) Response

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

Response Transaction Header Segment Questions	Check	Claim Reversal – Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Reversal – Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
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 Status Segment Questions	Check	Claim Reversal – Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	

Response Claim Segment Questions	Check	Claim Reversal – Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Reversal – Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	NCDHHS will return the Rx # received in the request transaction.

5.2.2 Claim Reversal Response (Transmission Accepted / Transaction Rejected)

Response Transaction Header Segment Questions	Check	Claim Reversal – Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Reversal – Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
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 Segment Questions	Check	Claim Reversal – Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	NCDHHS will return the Message Segment if a B2 Reversal transaction count is greater than ‘1’.

	Response Message Segment Segment Identification (111-AM) = “2Ø”			Claim Reversal – Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
5Ø4-F4	MESSAGE	“Resubmit Additional Reversal Transaction separately”	R	*Imp Guide:* Required if text is needed for clarification or detail. *Payer Requirement:* NCDHHS will return the Message Segment on a B2 Reversal if the transaction count is greater than ‘1’.

Response Status Segment Questions	Check	Claim Reversal – Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
51Ø-FA	REJECT COUNT		R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.

Response Claim Segment Questions	Check	Claim Reversal – Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Reversal – Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	NCDHHS will return the Rx # received in the request transaction.

5.2.3 Claim Reversal Response (Transmission Rejected / Transaction Rejected)

Response Transaction Header Segment Questions	Check	Claim Reversal – Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Reversal – Rejected/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
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 Status Segment Questions	Check	Claim Reversal – Rejected/Rejected If Situational, *Payer Situation*
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	
51Ø-FA	REJECT COUNT		R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.

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

6. Information Reporting / Information Rebill

6.1 INFORMATION REPORTING / INFORMATION REBILL REQUEST

6.1.1 Information Reporting / Information Rebill Request (Payer Sheet)

**** Start of Request Information Reporting /Information Reporting Rebill (N1/N3) Payer Sheet ****

GENERAL INFORMATION

Payer Name: North Carolina Department of Health and Human Services (NCDHHS)	Date: 11/07/2011	
Plan Name/Group Name: NCTracks	BIN: 610242	PCN: NCTracks ID
Processor: CSRA		
Effective as of: 07/21/2011	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: 07/2007	NCPDP External Code List Version Date: 09/2010	
Contact/Information Source: Provider Manuals available at www.nctracks.com/content/public/providers/provider-manuals.html General Website www.nctracks.nc.gov		
Provider Relations Help Desk Info: MEVS Unit 1-866-844-1113		
Other versions supported:		

OTHER TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal
B3	Claim Rebill
E1	Eligibility Verification
N2	Information Reporting 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 Information Reporting/Information Reporting Rebill transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

INFORMATION REPORTING/INFORMATION REPORTING 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	Information Reporting/Information Reporting Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Information Reporting/Information Reporting Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø1-A1	BIN NUMBER	610242	M	BIN for NCTracks
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	N1, N3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	1 = One occurrence 2 = Two occurrences 3 = Three occurrences 4 = Four occurrences	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider ID	M	
2Ø1-B1	SERVICE PROVIDER ID		M	10-digit NPI
4Ø1-D1	DATE OF SERVICE		M	Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Blank fill

Insurance Segment Questions	Check	Information Reporting/Information Reporting Rebill If Situational, *Payer Situation*
This Segment is always sent	X	

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Information Reporting/Information Reporting Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
3Ø2-C2	CARDHOLDER ID		M	10-digit recipient NC Medicaid Identification (MID) Number.
312-CC	CARDHOLDER FIRST NAME		M	
313-CD	CARDHOLDER LAST NAME		M	

Patient Segment Questions	Check	Information Reporting/Information Reporting Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
This Segment is situational		

	Patient Segment Segment Identification (111-AM) = "Ø1"			Information Reporting/Information Reporting Rebill
Field	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
332-CY	PATIENT ID		R	10-digit recipient NC Medicaid Identification (MID) Number.
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE	1 = Male 2 = Female	R	
31Ø-CA	PATIENT FIRST NAME		RW	*Imp Guide:* Required when the patient has a first name. *Payer Requirement:* As above.
311-CB	PATIENT LAST NAME		R	
3Ø7-C7	PLACE OF SERVICE	All code set values supported CMS Maintained code set	R	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* NC DHHS will source all data from the Patient Residence rather than from the new Place of Service.
384-4X	PATIENT RESIDENCE	Ø = 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	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* As above.

	Patient Segment Segment Identification (111-AM) = "Ø1"			Information Reporting/Information Reporting Rebill
Field	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		15 = Correctional Institution		
335-2C	PREGNANCY INDICATOR	Blank = Not Specified 1 = Not pregnant 2 = Pregnant	RW	*Imp Guide:* Required if pregnancy could result in different coverage, pricing, or patient financial responsibility. Required if "required by law" as defined in the HIPAA final Privacy regulations section 164.5Ø1 definitions (45 CFR Parts 16Ø and 164 Standards for Privacy of Individually Identifiable Health Information; Final Rule- Thursday, December 28, 2ØØØ, page 828Ø3 and following, and Wednesday, August 14, 2ØØ2, page 53267 and following.) *Payer Requirement:* Required when the member is known to be pregnant.

Claim Segment Questions	Check	Information Reporting/Information Reporting Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
This payer supports partial fills		
This payer does not support partial fills	X	

	Claim Segment Segment Identification (111-AM) = "Ø7"			Information Reporting/Information Reporting Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* 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	The prescription number assigned by the pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = NDC	M	Ø1 = UPC – is not used for DHB or DPH claims at this time.

	Claim Segment Segment Identification (111-AM) = "Ø7"			Information Reporting/Information Reporting Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
4Ø7-D7	PRODUCT/SERVICE ID		M	If billing for a multi-ingredient prescription, Product/Service ID (4Ø7-D7) is zero. (Zero means "Ø".) NCDHHS requires an NDC code or 0 (zero).
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	Ø = Not Specified 1 = Not Compound 2 = Compound	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Ø = No Product Selection Indicated 1 = Substitute Not Allowed by Prescriber 5 = Sub Allowed-Brand Drug Dispensed as Generic 7 = Sub Not Allowed-Brand Drug Mandated by Law 8 = Sub Allowed-Generic Drug Not Avail. in Market 9 = Sub Allowed By Prescriber-Plan Requests Brand	R	NCDHHS requires one of the listed codes to process a claim.
414-DE	DATE PRESCRIPTION WRITTEN		R	
419-DJ	PRESCRIPTION ORIGIN CODE	1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile 5 = Pharmacy	R	*Imp Guide:* Required if necessary for plan benefit administration.
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3	RW	*Imp Guide:* Required if Submission Clarification Code (42Ø-DK) is used. *Payer Requirement:* As above.
42Ø-DK	SUBMISSION CLARIFICATION CODE	Ø2 = Other Override Ø3 = Vacation Supply Ø4 = Lost Prescription Ø5 = Therapy Change 1Ø = Meets Plan Limitations 11 = Certification on file 2Ø = 340B Provider	RW	*Imp Guide:* Required if clarification is needed and value submitted is greater than zero (Ø). *Payer Requirement:* Required if clarification is needed when value submitted is greater than zero (Ø). NCDHHS will process up to three occurrences of the codes listed.
418-DI	LEVEL OF SERVICE	Ø = Not Specified	RW	*Imp Guide:* Required if this field

	Claim Segment Segment Identification (111-AM) = "Ø7"			Information Reporting/Information Reporting Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		1 = Patient consultation 2 = Home delivery 3 = Emergency 4 = 24 hour service 5 = Patient consultation regarding generic product selection 6 = In-Home Service		could result in different coverage, pricing, or patient financial responsibility.

Pricing Segment Questions	Check	Information Reporting/Information Reporting Rebill If Situational, *Payer Situation*
This Segment is always sent	X	

	Pricing Segment Segment Identification (111-AM) = "11"			Information Reporting/Information Reporting Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
43Ø-DU	GROSS AMOUNT DUE		R	

Prescriber Segment Questions	Check	Information Reporting/Information Reporting Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
This Segment is situational		

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			Information Reporting/Information Reporting Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 NPI	R	*Imp Guide:* Required if Prescriber ID (411-DB) is used. *Payer Requirement:* NCDHHS requires the NPI qualifier.
411-DB	PRESCRIBER ID		R	*Imp Guide:* Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs.

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			Information Reporting/Information Reporting Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				Payer Requirement: NCDHHS requires the NPI of the prescriber.

Clinical Segment Questions	Check	Information Reporting/Information Reporting Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
This Segment is situational		

	Clinical Segment Segment Identification (111-AM) = "13"			Information Reporting/Information Reporting Rebill
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 3	RW	*Imp Guide:* Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. *Payer Requirement:* Same as Imp Guide.
492-WE	DIAGNOSIS CODE QUALIFIER	NCDHHS expects 'Ø1' = ICD9 coding 'Ø2' = ICD10 (Future use)	RW	*Imp Guide:* Required if Diagnosis Code (424-DO) is used. *Payer Requirement:* NC Medicaid uses value "Ø1" – International Classification of Diseases (ICD9).
424-DO	DIAGNOSIS CODE	ICD9 code identifying diagnosis of the patient	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs.

**** End of Request Information Reporting/Information Reporting Rebill (N1/N3) Payer Sheet ****

6.2 INFORMATION REPORTING / INFORMATION REBILL RESPONSE

6.2.1 Information Reporting / Information Rebill Response (Accepted/Captured (or Duplicate of Captured))

**** Start of Response Information Reporting/Information Reporting Rebill (N1/N3) Payer Sheet ****

GENERAL INFORMATION

Payer Name: North Carolina Department of Health and Human Services (NCDHHS)		Date: 11/07/2011
Plan Name/Group Name: NCTracks	BIN: 610242	PCN: NCTracks ID

Information Reporting/Information Reporting Rebill captured (or Duplicate of captured) Response

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

Response Transaction Header Segment Questions	Check	Information Reporting/Information Reporting Rebill Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Information Reporting/Information Reporting Rebill – Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	N1, N3	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 Status Segment Questions	Check	Information Reporting/Information Reporting Rebill Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Information Reporting/Information Reporting Rebill – Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	A = Approved C = Captured	M	NCDHHS will return 'A'.
5Ø3-F3	AUTHORIZATION NUMBER		R	TCN is returned in this field on a Captured Paid or Rejected Response.

Response Claim Segment Questions	Check	Information Reporting/Information Reporting Rebill Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Information Reporting/Information Reporting Rebill – Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "N1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	NCDHHS will return the Prescription/Service Reference Number submitted.

6.2.2 Information Reporting / Information Rebill Response (Transmission Accepted / Transaction Rejected)

Response Transaction Header Segment Questions	Check	Information Reporting/Information Reporting Rebill Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Information Reporting/Information Reporting Rebill Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	N1, N3	M	

	Response Transaction Header Segment			Information Reporting/Information Reporting Rebill Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
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 Status Segment Questions	Check	Information Reporting/Information Reporting Rebill Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Information Reporting/Information Reporting Rebill Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
51Ø-FA	REJECT COUNT		R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.

Response Claim Segment Questions	Check	Information Reporting/Information Reporting Rebill Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Information Reporting/Information Reporting Rebill Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "N1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	NCDHHS will return the value received in the request transaction.

6.2.3 Information Reporting / Information Rebill Response (Transmission Rejected / Transaction Rejected)

Response Transaction Header Segment Questions	Check	Information Reporting/Information Reporting Rebill Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Information Reporting/Information Reporting Rebill Rejected/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	N1, N3	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 Status Segment Questions	Check	Information Reporting/Information Reporting Rebill Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Information Reporting/Information Reporting Rebill Rejected/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
51Ø-FA	REJECT COUNT		R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.

**** End of Response Information Reporting/Information Reporting Rebill (N1/N3) Payer Sheet ****

7. Information Reporting Reversal

7.1 INFORMATION REPORTING REVERSAL REQUEST

7.1.1 Information Reporting Reversal Request (Payer Sheet)

**** Start of Request Information Reporting Reversal (N2) Payer Sheet ****

GENERAL INFORMATION

Payer Name: North Carolina Department of Health and Human Services (NCDHHS)	Date: 11/07/2011	
Plan Name/Group Name: NCTracks	BIN: 610242	PCN: NCTracks ID

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
NOT USED	NA	The Field is not used for the Segment in the designated Transaction. Not used are shaded for clarity for the Payer when creating the Template. For the actual Payer Template, not used fields must be deleted from the transaction (the row in the table removed).	No

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	1 Year

Information Reporting Reversal Transaction

The following lists the segments and fields in an Information Reporting Reversal Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Transaction Header Segment Questions	Check	Information Reporting Reversal If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Information Reporting Reversal
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø1-A1	BIN NUMBER	All requests must send '610242'	M	NCDHHS requires '610242'
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	N2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	1 = One occurrence 2 = Two occurrences 3 = Three occurrences 4 = Four occurrences	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider ID	M	
2Ø1-B1	SERVICE PROVIDER ID		M	10-digit NPI
4Ø1-D1	DATE OF SERVICE		M	Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	

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

	Claim Segment Segment Identification (111-AM) = "Ø7"			Information Reporting Reversal
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RX Billing	M	*Imp Guide:* For Transaction Code of "N2", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	The prescription number assigned by the pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = NDC	M	If billing for a multi-ingredient prescription, Product/Service ID Qualifier (436-E1) is zero ("ØØ"). NCDHHS requires one of these codes.
4Ø7-D7	PRODUCT/SERVICE ID		M	If billing for a multi-ingredient prescription, Product/Service ID (4Ø7-D7) is zero. (Zero means "Ø".) NCDHHS requires an NDC code, an HCPCS Code, or 0 (zero).

**** End of Request Information Reporting Reversal (N2) Payer Sheet ****

7.2 INFORMATION REPORTING REVERSAL RESPONSE

7.2.1 Information Reporting Reversal Response (Accepted/Captured (or Duplicate of Captured))

**** Start of Information Reporting Reversal Response ((N2) Payer Sheet ****

GENERAL INFORMATION

Payer Name: North Carolina Department of Health and Human Services (NCDHHS)	Date: 11/07/2011	
Plan Name/Group Name: NCTracks	BIN: 610242	PCN: NCTracks ID

Information Reporting Reversal accepted/captured (or duplicate of capture) Response

The following lists the segments and fields in an Information Reporting Reversal response (Captured or Duplicate of Captured) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Response Transaction Header Segment Questions	Check	Information Reporting Reversal – Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Information Reporting Reversal– Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	N2	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 Status Segment Questions	Check	Information Reporting Reversal – Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Information Reporting Reversal– Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	

Response Claim Segment Questions	Check	Information Reporting Reversal – Accepted/Captured (or Duplicate of Captured) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Information Reporting Reversal– Accepted/Captured (or Duplicate of Captured)
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "N2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	NCDHHS will return the Rx # received in the request transaction.

7.2.2 Information Reporting Reversal Response (Transmission Accepted / Transaction Rejected)

Response Transaction Header Segment Questions	Check	Information Reporting Reversal – Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Information Reporting Reversal– Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	N2	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 Status Segment Questions	Check	Information Reporting Reversal- Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = “21”			Information Reporting Reversal– Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	TCN is returned in this field on a Captured Paid or Rejected Response.
51Ø-FA	REJECT COUNT		R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.

Response Claim Segment Questions	Check	Information Reporting Reversal- Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Information Reporting Reversal– Accepted/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "N2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	NCDHHS will return the Rx # received in the request transaction.

7.2.3 Information Reporting Reversal Response (Transmission Rejected / Transaction Rejected)

Response Transaction Header Segment Questions	Check	Information Reporting Reversal- Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Information Reporting Reversal– Rejected/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	N2	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 Status Segment Questions	Check	Information Reporting Reversal- Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Information Reporting Reversal– Rejected/Rejected
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	TCN is returned in this field on a Captured Paid or Rejected Response.
51Ø-FA	REJECT COUNT		R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.

**** End of Information Reporting Reversal(N2) Response Payer Sheet ****