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Gap Analysis for NCPDP D.0 Billing

Version 1.0 April 2010

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OVERVIEW

PURPOSE

The purpose of this document is to provide a high level gap analysis between the current HIPAA mandated NCPDP version 5.1 and the NCPDP version D.0 that has a compliance date of January 1, 2012. This document is divided into sections for each functional use of the NCPDP Telecommunication Standard.

This document should be used along with the NCPDD Telecommunication Standard Implementation Guide. To obtain your copy of the NCPDP Telecommunication Standard Implementation go to the Web Site at:

http://ncpdp.org/standards_purchase.aspx

OVERALL GAP ANALYSIS REPORT

The Overall Gap Analysis Report provides a list of all content changes in the order of the NCPDP Telecommunication Standard Implementation Guide. Changes that were considered non-substantive are not listed in this report. The Change Comment gives a brief summary of the change and the columns listed to the right indicate the type of change.

NEW CONTENT REPORT

The New Content Report provides a list of NEW data elements added in the Version D.0 of the NCPDP Telecommunication Standard Implementation Guide.

DELETED CONTENT REPORT

The Deleted Content Report provides a list of the data elements REMOVED in the Version D.0 of the NCPDP Telecommunication Standard Implementation Guide Version D.0.

USE CHANGE REPORT

The Use Change Report provides a list of data elements where the Implementation usage changed from Situational to Required; Required to Situational; or the Situational Note changed in the NCPDP Telecommunication Standard Implementation Guide Version D.0.

SIZING CHANGE REPORT

The Sizing Change Report provides a list of data elements where the min/max requirements changed in NCPDP Telecommunication Standard Implementation Guide Version D.0.

CODE CHANGE REPORT

The Code Change Report provides a list of data elements where the code values within the data element were changed in the NCPDP Telecommunication Standard Implementation GuideVersion D.0

NCPDP D.0
BILLING
CODE CHANGES REPORT

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NCPDP D.0 Billing Gap Analysis
Code Changes

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Header	102-A2	Version/Release Number	Version release changed from 5.1 to D.0
Header	103-A3	Transaction Code	Value of B1 with 455-EM equal to 1 for Rx Billing.
Header	202-B2	Service Provider ID Qualifier	00 removed, 15 and 16 added
Patient	331-CX	Patient ID Qualifier	value blank removed, 04 - 11, 1J, EA added
Patient	324-CO	Patient State/Province Code	values YT,NT,NU,QC added, PQ removed
Patient	307-C7	Place of Service	values 02 and 09 removed; 12 - 16, 20 - 26, 31 - 34, 41, 42, 49 - 57,60 - 62, 65, 71, 72, 81, 99 added
Claim	455-EM	Prescription/Service Reference Number Qualifier	value blank removed
Claim	436-E1	Product/Service ID Qualifier	value blank, 05, and 13 removed, values 15, 27 - 34 added
Claim	459-ER	Procedure Modifier Code	Please check the referenced CMS web site referenced in the 5.1 & D.0 code values columns for the latest list of codes
Claim	419-DJ	Prescription Origin Code	value 5 added
Claim	420-DK	Submission Clarification Code	values 00, 10 through 19 added
Claim	308-C8	Other Coverage Code	Values: Modify definition: 8 = Claim is billing for patient financial responsibility only; 3=Other Coverage Billed – claim not covered; Ø= Not specified by patient. Values 05, 06, 07 removed
Claim	429-DT	Special Packaging Indicator	values 4 and 5 added
Claim	453-EJ	Original Prescribed Product/Service ID Qualifier	values blank, 05, and 13 removed and 15, 28 - 33 added

Segment	Field	Description	D.0 Change Comment
Claim	461-EU	Prior Authorization Type Code	value 09 added. Also note that the definition for value 04 changed to, 'Exemption from Copay and/or Coinsurance'.
Claim	343-HD	Dispensing Status	value blank removed
Pharmacy Provider	465-EY	Provider ID Qualifier	value blank removed
Prescriber	466-EZ	Prescriber ID Qualifier	value blank and 07 removed, 15 added
Prescriber	468-2E	Prescriber Phone Number	value 00 and 07 removed, 15 added
COB/other payments	338-5C	Other Payer Coverage Type	values 98 and 99 removed, 04 - 09 added
COB/other payments	339-6C	Other Payer ID Qualifier	value 05 added, blank and 09 removed
COB/other payments	342-HC	Other Payer Amount Paid Qualifier	values blank, 08, 98, 99 removed

Segment	Field	Description	D.0 Change Comment
COB/other payments	472-6E	Other Payer Reject Code	values 1E,38,H5,RE,TE,and,UE removed, 201,2Ø2,2Ø3,2Ø4,2Ø5,2Ø6,2Ø7,2Ø8,2Ø9,21Ø,211,212, 213,214,215,216,217,218,219,22Ø,221,222,223,224,225 ,226,227,228,229,23Ø,231,232,233,234,235,236,237,23 8,239,24Ø,241,242,243,244,245,246,247,248,249,251,2 52,253,254,255,256,257,258,259,26Ø,261,262,263,264, 265,266,267,268,269,27Ø,271,272,273,274,275,276,277 ,278,279,28Ø,281,282,283,284,285,286,287,288,289,29 Ø,291,292,293,294,295,296,297,298,299,3ØØ,3Ø1,3Ø2, 3Ø3,3Ø4,3Ø5,3Ø6,3Ø7,3Ø8,3Ø9,31Ø,311,312,313,314,3 15,316,317,318,319,32Ø,321,322,323,324,325,326,327, 328,329,33Ø,331,332,333,334,335,336,337,338,339,34Ø ,341,342,343,344,345,346,347,348,349,35Ø,351,352,35 3,354,355,356,357,358,359,36Ø,361,363,364,365,366,3 67,368,369,37Ø,371,372,373,374,375,376,377,378,379, 38Ø,381,382,383,384,385,386,387,388,389,39Ø,391,392 ,393,394,395,396,397,398,399,4ØØ,4Ø1,4Ø2,4Ø3,4Ø4,4 Ø5,4Ø6,4Ø7,4Ø9,41Ø,411,412,413,414,415,416,417,418 ,419,42Ø,421,422,423,424,425,426,427,428,429,43Ø,43 1,432,433,434,435,436,437,438,439,44Ø,441,442,443,4 45,446,447,448,449,45Ø,451,452,453,454,455,456,457, 458,459,46Ø,461,462,463,1R,1S,1T,1U,1V,1W,1X,1Y,1Z, 2A,2B,2D,2G,2H,2J,2K,2M,2N,2P,2Q,2R,2S,2T,2U,2V,2W, 2X,2Z,2G,2H,2J,2K,2M,2N,2P,2Q,2R,2S,2T,2U,2V,2W,2X, 2Z,3Q,3U,3V,4B,4D,4G,4J,4K,4M,4N,4P,4Q,4R,4S,4T,4W, 4X,4Y,4Z,5J,6D,6G,6H,6J,6N,6P,6Q,6R,6S,6T,6U,6V,6W,6 X,6Z,7B,7D,7F,7G,7J,7K,7M,7N,7P,7Q,7R,7S,7T,7U,7V,7 W,7X,7Y,7Z,8A,8B,8D,8G,8H,8J,8K,8M,8N,8P,8Q,8R,8S,8 T,8U,8V,8W,8X,8Y,8Z,9B,9C,9D,9E,9G,9H,9J,9K,9M,9N,9 P,9Q,9R,9S,9T,9U,9V,9W,9X,9Y,9Z,A1,A2,A5,A6,A7,AQ,B A,BB,BC,BD,BF,BG,BH,BJ,BK,BM,E2,EH,G1,G2,G4,G5,G6,G 7,G8,G9,HN,K5,MG,MH,MJ,MK,MM,MN,MP,MR,MT,MU, MV,MW,MX,MY,NA,NB,NC,NF,NG,NH,NJ,NK,NP,NQ,NR, NU,NV,NW,NX,NY,N1,N3,N4,N5,N6,N7,N8,N9,PQ,PU,PØ, RL,RQ,RR,RV,RW,RX,RY,RZ,RØ,SØ,S1,S2,S3,S4,S5,S6,S7,S8 ,S9,SA,SB,SC,SD,SF,SG,SH,SJ,SK,SM,SN,SP,SQ,TD,TF,TG,TH ,TJ,TK,TM,TN,TQ,TR,TS,TT,TU,TV,TX,TY,TZ,TØ,T1,T2,T3,T4 ,UA,UU,WØ,W5,W6,W7,W8,W9,XZ,X1,X2,X3,X4,X6,X7,X 8,X9,YA,YB,YC,YD,YE,YF,YG,YH,YJ,YK,YM,YN,YP,YQ,YR,YS,

Segment	Field	Description	D.0 Change Comment
	472-6E		YT,YU,YW,YX,YY,YZ,YØ,Y1,Y2,Y3,Y4,Y5,Y6,Y7,Y8,Y9,ZØ,Z1, Z2,Z3,Z4,Z5,Z6,Z7,Z8,Z9,ZA,ZB,ZC,ZD,ZK,ZM,ZN,ZP,ZQ,ZX, ZY,ZZ,UZ,UØ,U7,VA,VB,VC,VD,VE,VØ,ZD added
Workers Compensation	318-CI	Employer State/Province Code	values YT,NT,NU,QC added, PQ removed
DUR/PPS	439-E4	Reason for Service Code	values DR added, PC,SF,SR,SX,TD,TN and TP removed
DUR/PPS	440-E5	Professional Service Code	values DP,MB,MP,PA,ZZ,AD,AN,AR,AT,CD,CH,CS,DA,DC,DD,DF,D I,DL,DM,DR,DS,ED,ER,EX,HD,IC,ID,LD,LK,LR,MC,MN,MS, MX,NA,NC,ND,NF,NN,NP,NR,NS,OH,PA,PC,PG,PN,PP,PR, PS,RE,RF,SC,SD,SE,SF,SR,SX added
DUR/PPS	441-E6	Result of Service Code	value 4A added
DUR/PPS	475-J9	DUR CO-Agent ID Qualifier	values blank & 13 removed, 27 - 33, 35, 37 added
Pricing	479-H8	Other Amount Claimed Submitted Qualifier	value blank removed and 09 added
Pricing	423-DN	Basis of Cost Determination	value blank removed and 08, 10 - 13 added
Coupon	485-KE	Coupon Type	value blank removed
Compound	488-RE	Compound Ingredient Component Count	values blank, 05, and 13 removed, 15, 28 - 33 added
Compound	490-UE	Compound Ingredient Drug Cost	values 00, 08, 10 - 12 added; blank removed
Clinical	492-WE	Diagnosis Code Qualifier	values 08 and 09 added; blank removed
Clinical	496-H2	Measurement Dimension	values 18 - 34 added
Clinical	497-H3	Measurement Unit	values 19 - 27 added
Response Header	103-A3	Transaction Code	B1 & field 455-EM=1 for RX Billing
Response Header	202-B2	Service Provider ID Qualifier	00 removed, 15 and 16 added
Response Status	112-AN	Transaction Response Status	value B added

Segment	Field	Description	D.0 Change Comment
Response Status	511-FB	Reject Code	values 1E,38,H5,RE,TE,and,UE removed,201,2Ø2,2Ø3,2Ø4,2Ø5,2Ø6,2Ø7,2Ø8,2Ø9,21Ø, 211,212,213,214,215,216,217,218,219,22Ø,221,222,223 ,224,225,226,227,228,229,23Ø,231,232,233,234,235,23 6,237,238,239,24Ø,241,242,243,244,245,246,247,248,2 49,251,252,253,254,25
Response Status	549-7F	Help Desk Phone Number Qualifier	value blank removed
Response Claim	552-AP	Preferred Product ID Qualifier	values blank, 5, and 13 removed, 28 - 33, 37 added
Response Pricing	557-AV	Tax Exempt Indicator	value 2 removed, 3 and 4 added
Response Pricing	561-AZ	Percentage Sales Tax Basis Paid	01 removed
Response Pricing	564-J3	Other Amount Paid Qualifier	value blank removed and 09 was added
Response Pricing	522-FM	Basis of Reimbursement Determination	values 10 - 17 added
Response Pricing	346-HH	Amount Exceeding Periodic Benefit Maximum	values blank and 00 removed
Response Pricing	347-HJ	Basis of Calculation-Dispensing Fee	values blank and 00 removed
Response DUR/PPS	439-E4	Reason for Service Code	Values DR and UD added
Response DUR/PPS	528-FS	Clinical Significance Code	value 9 added
Response DUR/PPS	532-FW	Database Indicator	value blanks removed, 6 and 7 added
Response Coordination of Benefits/Other Payments	338-5C	Other Payer Coverage Type	values 04 - 09 added, 98 and 99 removed
Response Coordination of Benefits/Other Payments	339-6C	Other Payer ID Qualifier	values 05 added, 09 removed

NCPDP D.0
BILLING
DELETED CONTENT REPORT

NCPDP D.0 Billing Gap Analysis
Deleted Content

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Prescriber	467-1E	Prescriber Location Code	Removed in prior version
Prescriber	469-H5	Primary Provider Location Code	Removed in prior version
Compound	452-EH	Compound route of Administration	Removed in prior version
Response Pricing	519-FJ	Amount Attributed To Product Selection	Removed in prior version

NCPDP D.0
BILLING
NEW CONTENT REPORT

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Patient	350-HN	Patient E-mail Address	May be submitted for the receiver to relay patient healthcare communications via the Internet when provided by the patient. This field is informational only.
Patient	384-4X	Patient Residence	Required if this field could result in different coverage,pricing, or patient financial responsibility.
Insurance	990-MG	Other Payer BIN Number	Required for Medicare Part D payer-to-payer facilitation when necessary to match the information reporting reversal transaction to the original information reporting transaction.
Insurance	991-MH	Other Payer Processor Code	Required if other insurance information is available for coordination of benefits.
Insurance	356-NU	Other Payer Cardholder ID	Required for Medicare Part D payer-to-payer facilitation when necessary to match the information reporting reversal transaction to the original information reporting transaction.
Insurance	992-MJ	Other Payer Group ID	Required for Medicare Part D payer-to-payer facilitation when necessary to match the information reporting reversal transaction to the original information reporting transaction.
Insurance	359-2A	Medigap ID	Required, if known, when patient has Medigap coverage.
Insurance	360-2B	Medicaid Indicator	Required, if known, when patient has Medigap coverage.
Insurance	361-2D	Provider Accept Assignment Indicator	Required if necessary for state/federal/regulatory agency programs

Segment	Field	Description	D.0 Change Comment
Insurance	997-G2	CMS PART D Defined Qualified Facility	Required if specified in trading partner agreement.
Insurance	115-N5	Medicaid ID Number	Required, if known, when patient has Medicaid coverage. Required when used for payer-to-payer coordination of benefits to track the claim without regard to the “Service Provider ID, Prescription Number, & Date of Service”.
Insurance	116-N6	Medicaid Agency Number	Required if the identification to be used in future transactions is different than what was submitted on the request.
Claim	354-NX	Submission Clarification Code Count	new - maximum of 3 occurrences. Required if Submission Clarification Code (42Ø-DK) is used.
Claim	357-NV	Delay Reason code	Required when needed to specify the reason that submission of the transaction has been delayed.
Claim	880-K5	Transaction Reference Number	Required for Medicare Part D payer-to-payer facilitation to match the transaction response to the transaction.
Claim	391-MT	Patient Assignment Indicator (Direct Member Reimbursement Indicator)	Required if needed per trading partner agreement.
Claim	995-E2	Route of Admission	Required if needed per trading partner agreement.
Claim	996-G1	Compound Type	Required if needed per trading partner agreement.
Claim	114-N4	Medicaid Subrogation internal Control Number/Transaction Control Number (ICN/TCN)	Required to report back on the response the claim number assigned by the Medicaid Agency.
Claim	147-U7	Pharmacy Service Type	Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer see Appendix 28.1.9 of the version D.0 Telecommunication Standard Implementation guide for details.
Prescriber	364-2J	Primary Care Provider Last Name	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.

Segment	Field	Description	D.0 Change Comment
Prescriber	365-2K	Primary Care Provider First Name	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.
Prescriber	366-2M	Prescriber Street Address	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.
Prescriber	367-2N	Prescriber City Address	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.
Prescriber	368-2P	Prescriber State/Province Code	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.
COB/other payments	993-A7	Internal Control Number	Required when used for payer-to-payer coordination of benefits to track the claim without regard to the "Service provider id, Prescription Number, & Date of Service".
COB/other payments	353-NR	Other Payer-Patient Responsibility Amount Count	New - maximum 25 occurrences. Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. Note the occurrences are dependent upon the number of component parts returned from a previous payer.
COB/other payments	351-NP	Other Payer-Patient Responsibility Amount Qualifier	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. Values 02,08, Ø9, 1Ø, 11, 12, and 13
COB/other payments	352-NQ	Other Payer-Patient Responsibility Amount	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.
COB/other payments	392-MU	Benefit Stage Count	New - maximum count 4. Required if Benefit Stage Amount (394-MW) is used.

Segment	Field	Description	D.0 Change Comment
COB/other payments	393-MV	Benefit Stage Qualifier	Required if Benefit Stage Amount (394-MW) is used. Must only have one value per iteration - value must not be repeated.
COB/other payments	394-MW	Benefit Stage Amount	Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefitstage specific financial amounts. Required if necessary for state/federal/regulatory agency programs.
Workers Compensation	117-TR	Billing Entity Type Indicator	This field is required for Rebill of claims or services and for Prior Authorization Request & Billing for claims and services.
Workers Compensation	118-TS	Pay-To Qualifier	Required if Pay To ID (119-TT) is used.
Workers Compensation	119-TT	Pay-To ID	Required if transaction is submitted by a provider or agent, ut paid to another party.
Workers Compensation	120-TU	Pay-To Name	Required if transaction is submitted by a provider or agent, ut paid to another party.
Workers Compensation	121-TV	Pay-To Street Address	Required if transaction is submitted by a provider or agent, but paid to another party.
Workers Compensation	122-TW	Pay-To City Address	Required if transaction is submitted by a provider or agent, but paid to another party.
Workers Compensation	123-TX	Pay-To State/Province Code	Required if transaction is submitted by a provider or agent, but paid to another party.
Workers Compensation	124-TY	Pay-To Zip/Postal Code	Required if transaction is submitted by a provider or agent, but paid to another party.
Workers Compensation	125-TZ	Generic Equivalent Product ID Qualifier	Required if Generic Equivalent Product ID (126-UA) is used.
Workers Compensation	126-UA	Generic Equivalent Product ID	Required if necessary for state/federal/regulatory agency programs.
Pricing	113-N3	Medicaid Paid Amount	Required if affects pricing in Medicaid Subrogation (contains the amount paid to the pharmacy).

Segment	Field	Description	D.0 Change Comment
Compound	362-2G	Compound Ingredient Basis of Cost Determination	Required when Compound Ingredient Modifier Code (363-2H) is sent. Maximum count of 10.
Compound	363-2H	Compound Ingredient Modifier Code Count	Required if necessary for state/federal/regulatory agency programs.
Additional Documentation Segment	14		New - The Additional Documentation Segment is situational for Claim Billing or Encounter request. It is used to provide additional information on Medicare forms.
Additional Documentation	369-2Q	Additional Documentation Type ID	Unique identifier for the data being submitted. Values 001-015
Additional Documentation	374-2V	Request Period Begin Date	Required if necessary for state/federal/regulatory agency programs.
Additional Documentation	375-2W	Request Period Recert/Revised Date	Required if necessary for state/federal/regulatory agency programs. Required if the Request Status (373-2U) = “2” (Revision) or “3” (Recertification).
Additional Documentation	373-2U	Request Status	Required if necessary for state/federal/regulatory agency programs.
Additional Documentation	371-2S	Length of Need Qualifier	Required if Length of Need (370-2R) is used.
Additional Documentation	370-2R	Length of Need	Required if necessary for state/federal/regulatory agency programs.
Additional Documentation	372-2T	Prescriber/Supplier Date Signed	Required if necessary for state/federal/regulatory agency programs.
Additional Documentation	376-2X	Supporting Documentation	Required if necessary for state/federal/regulatory agency programs (using Section C of Medicare’s CMN forms).
Additional Documentation	377-2Z	Question Number/Letter Count	New - maximum 50 occurrences. Required if needed to provide response to narratives.
Additional Documentation	378-4B	Question Number/Letter	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form. Required if Question Number/Letter Count (377-2Z) is greater than 0.

Segment	Field	Description	D.0 Change Comment
Additional Documentation	379-4D	Question Percent Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)
Additional Documentation	380-4G	Question Date Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)
Additional Documentation	381-4H	Question Dollar Amount Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)
Additional Documentation	382-4J	Question Numeric Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)
Additional Documentation	383-4K	Question Alphabetic Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)
Facility Segment	15		The Facility Segment is situational for Claim Billing or Encounter request. It is used when these fields could result in different coverage,pricing, patient financial responsibility, and/or drug utilization review outcome.
Facility	385-3Q	Facility Name	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.
Facility	386-3U	Facility Street Address	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.

Segment	Field	Description	D.0 Change Comment
Facility	388-5J	Facility City Address	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.
Facility	387-3V	Facility State/Province Code	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.
Facility	389-6D	Facility Zip/Postal Code	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.
Narrative Segment	16		Segment requirement changed from optional to not used for all transaction types checked.
Narrative	390-BM	Narrative Message	The Narrative Segment is situational for Claim Billing or Encounter request. It is used to support exception handling of pharmacy claims for Medicare claim billing.
Response Insurance	115-N5	Medicaid ID Number	Required, if known, when patient has Medicaid coverage. Required when used for payer-to-payer coordination of benefits to track the claim without regard to the “Service Provider ID, Prescription Number, & Date of Service”.
Response Insurance	116-N6	Medicaid Agency Number	Required to identify the Medicaid agency.
Response Patient Segment	29		New Segment added with D.0. This segment is used for Medicare Part D Eligibility transactions to provide patient name and date of birth in order to provide additional patient information. This information could assist in the verification that the eligibility information returned is indeed the patient for which the eligibility request was intended.This segment can be sent response/transaction types except for when the response is transmission rejected/transaction rejected.
Response Status	548-6F	Approved Message Code	Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. This field repeats the number of times indicated in field 547-5f.

Segment	Field	Description	D.0 Change Comment
Response Status	130-UF	Additional Message Information Count	Required if Additional Message Information (526-FQ) is used. Used to qualify the number of occurrences of the Additional Message Information (526-FQ) that is included in the Response Status Segment. Maximum number of occurences is 25.
Response Status	132-UH	Additional Message Information Qualifier	Required if Additional Message Information (526-FQ) is used.
Response Status	131-UG	Additional Message Information Continuity	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.
Response Status	993-A7	Internal Control Number	Required when used for payer-to-payer coordination of benefits to track the claim without regard to the "Service provider id, Prescription Number, & Date of Service".
Response Status	987-MA	URL	Provided for informational purposes only to relay healthcare communications via the Internet.
Response Claim	114-N4	Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)	Required to report back on the response the claim number assigned by the Medicaid Agency.
Response Pricing	571-NZ	Basis of Calculation-Percentage Sales Tax	Required if the customer is responsible for 100% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay.
Response Pricing	575-EQ	Amount Attributed to Processor Fee	Used when necessary to identify the Patient's portion of the Sales Tax. Provided for informational purposes only.
Response Pricing	574-2Y	Patient Sales Tax Amount	Used when necessary to identify the Plan's portion of the Sales Tax. Provided for informational purposes only.
Response Pricing	572-4U	Plan Sales Tax Amount	Required if Patient Pay Amount (5Ø5-F5) includes coinsurance as patient financial responsibility.

Segment	Field	Description	D.0 Change Comment
Response Pricing	573-4V	Amount of Coinsurance	Required if Dispensing Status (343-HD) on submission is “P” (Partial Fill) or “C” (Completion of Partial Fill).
Response Pricing	392-MU	Basis of Calculation-Coinsurance	New - maximum 3 occurrences. Required if Benefit Stage Amount (394-MW) is used.
Response Pricing	393-MV	Benefit Stage Count	Required if Benefit Stage Amount (394-MW) is used. Must only have one value per iteration - value must not be repeated.
Response Pricing	394-MW	Benefit Stage Qualifier	Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs.
Response Pricing	577-G3	Benefit Stage Amount	This information should be provided when a patient selected the brand drug and a generic form of the drug was available. It will contain an estimate of the difference between the cost of the brand drug and the generic drug, when the brand drug is more expensive than the generic. It is information that the provider should provide to the patient.
Response Pricing	128-UC	Estimated Generic Savings	This dollar amount will be provided, if known, to the receiver when the transaction had spending account dollars reported as part of the patient pay amount. This field is informational only. It is reported back to the provider and the patient the amount remaining on the spending account after the current claim updated the spending account.
Response Pricing	129-UD	Spending Account Amount Remaining	Required when the patient meets the plan-funded assistance criteria, to reduce Patient Pay Amount (5Ø5-F5). The resulting Patient Pay Amount (5Ø5-F5) must be greater than or equal to zero. This field is always a negative amount or zero.

Segment	Field	Description	D.0 Change Comment
Response Pricing	133-UJ	Health Plan-Funded Assistance Amount	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another.
Response Pricing	134-UK	Amount Attributed to Provider Network Selection	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand drug.
Response Pricing	135-UM	Amount Attributed to Product Selection/Brand Drug	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a nonpreferred formulary product.
Response Pricing	136-UN	Amount Attributed to Product Selection/Non-Preferred Formulary Selection	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand non-preferred formulary product.
Response Pricing	137-UP	Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection	Required when the patient's financial responsibility is due to the coverage gap.
Response Pricing	148-U8	Amount Contributed to Coverage Gap	Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency. This field is informational only.
Response Pricing	149-U9	Ingredient Cost Contracted/Reimbursable Amount	Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15"(Patient Pay Amount) unless prohibited by state/federal/regulatory agency. This field is informational only.
Response COB/other payments Segment	28		New segment added with D.0 - The Response Coordination of Benefits/Other Payers Segment is situational for a Service Billing response when the Header Response Status (5Ø1-F1) of "A" (Accepted) and Transaction Response Status (112-AN) of "P" (Paid) or "D" (Duplicate of Paid) when other insurance information is available for coordination of benefits. If subsequent payer(s) for this patient is not known, the Other Payer information\ is not sent.

Segment	Field	Description	D.0 Change Comment
Response Coordination of Benefits/Other Payments	355-NT	Other Payer ID Count	New - maximum 3 occurrences. Count of other payers with payment responsibility.
Response Coordination of Benefits/Other Payments	991-MH	Other Payer Processor Control Number	Required if other insurance information is available for coordination of benefits.
Response Coordination of Benefits/Other Payments	356-NU	Other Payer Cardholder ID	Required if other insurance information is available for coordination of benefits.
Response Coordination of Benefits/Other Payments	992-MJ	Other Payer Group Id	Required if other insurance information is available for coordination of benefits.
Response Coordination of Benefits/Other Payments	142-UV	Other Payer Person Code	Required if needed to uniquely identify the family members within the CardholderID, as assigned by the other payer.
Response Coordination of Benefits/Other Payments	127-UB	Other Payer Help Desk Phone Number	Required if needed to provide a support telephone number f the other payer to the receiver.
Response Coordination of Benefits/Other Payments	143-UW	Other Payer Patient Relationship Code	Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer.
Response Coordination of Benefits/Other Payments	144-UX	Other Payer Benefit Effective Date	Required when other coverage is known which is after the Date of Service submitted.
Response Coordination of Benefits/Other Payments	145-UY	Other Payer Benefit Termination Date	Required when other coverage is known which is after the Date of Service submitted.

NCPDP D.0
BILLING
OVERALL CHANGE REPORT

Items in Red are flagged as Transitions Challenges

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Header	102-A2	Version/Release Number	Version release changed from 5.1 to D.0						
Header	103-A3	Transaction Code	Value of B1 with 455-EM equal to 1 for Rx Billing.						
Header	202-B2	Service Provider ID Qualifier	00 removed, 15 and 16 added						
Patient Segment	01		The Patient Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when a receiver needs some of the patient demographic information to perform eligibility and claim/encounter determination. The Patient Segment must be submitted when needed to differentiate between the patient and the cardholder. If the cardholder and the patient are the same, then the Patient Segment is not submitted unless additional information about the patient is needed to clarify the claim/encounter determination. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.						
Patient	331-CX	Patient ID Qualifier	value blank removed, 04 - 11, 1J, EA added						
Patient	324-CO	Patient State/Province Code	values YT,NT,NU,QC added, PQ removed						
Patient	307-C7	Place of Service	values 02 and 09 removed; 12 - 16, 20 - 26, 31 - 34, 41, 42, 49 - 57,60 - 62, 65, 71, 72, 81, 99 added						
Patient	350-HN	Patient E-mail Address	May be submitted for the receiver to relay patient healthcare communications via the Internet when provided by the patient. This field is informational only.						
Patient	384-4X	Patient Residence	Required if this field could result in different coverage,pricing, or patient financial responsibility.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Insurance	990-MG	Other Payer BIN Number	Required for Medicare Part D payer-to-payer facilitation when necessary to match the information reporting reversal transaction to the original information reporting transaction.						
Insurance	991-MH	Other Payer Processor Code	Required if other insurance information is available for coordination of benefits.						
Insurance	356-NU	Other Payer Cardholder ID	Required for Medicare Part D payer-to-payer facilitation when necessary to match the information reporting reversal transaction to the original information reporting transaction.						
Insurance	992-MJ	Other Payer Group ID	Required for Medicare Part D payer-to-payer facilitation when necessary to match the information reporting reversal transaction to the original information reporting transaction.						
Insurance	359-2A	Medigap ID	Required, if known, when patient has Medigap coverage.						
Insurance	360-2B	Medicaid Indicator	Required, if known, when patient has Medigap coverage.						
Insurance	361-2D	Provider Accept Assignment Indicator	Required if necessary for state/federal/regulatory agency programs						
Insurance	997-G2	CMS PART D Defined Qualified Facility	Required if specified in trading partner agreement.						
Insurance	115-N5	Medicaid ID Number	Required, if known, when patient has Medicaid coverage. Required when used for payer-to-payer coordination of benefits to track the claim without regard to the “Service Provider ID, Prescription Number, & Date of Service”.						
Insurance	116-N6	Medicaid Agency Number	Required if the identification to be used in future transactions is different than what was submitted on the request.						
Claim	455-EM	Prescription/Service Reference Number Qualifier	value blank removed						
Claim	**402-D2**	**Prescription/Service Reference Number**	**field lengthened from 7 to 12 bytes**						
Claim	436-E1	Product/Service ID Qualifier	value blank, 05, and 13 removed, values 15, 27 - 34 added						
Claim	**456-EN**	**Associated Prescription/Service Date Qualifier**	**field lengthened from 7 to 12 bytes**						
Claim	**458-SE**	**Procedure Modifier Code Count**	**maximum occurrences increased to 10 removed the recommend number of occurrences with D.0, field lengthened from 1 to 2 bytes**						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Claim	459-ER	Procedure Modifier Code	Please check the referenced CMS web site referenced in the 5.1 & D.0 code values columns for the latest list of codes						
Claim	419-DJ	Prescription Origin Code	value 5 added						
Claim	354-NX	Submission Clarification Code Count	new - maximum of 3 occurrences. Required if Submission Clarification Code (42Ø-DK) is used.						
Claim	420-DK	Submission Clarification Code	values 00, 10 through 19 added						
Claim	308-C8	Other Coverage Code	Values: Modify definition: 8 = Claim is billing for patient financial responsibility only; 3=Other Coverage Billed – claim not covered; Ø= Not specified by patient. Values 05, 06, 07 removed						
Claim	429-DT	Special Packaging Indicator	values 4 and 5 added						
Claim	453-EJ	Original Prescribed Product/Service ID Qualifier	values blank, 05, and 13 removed and 15, 28 - 33 added						
Claim	461-EU	Prior Authorization Type Code	value 09 added. Also note that the definition for value 04 changed to, 'Exemption from Copay and/or Coinsurance'.						
Claim	343-HD	Dispensing Status	value blank removed						
Claim	357-NV	Delay Reason code	Required when needed to specify the reason that submission of the transaction has been delayed.						
Claim	880-K5	Transaction Reference Number	Required for Medicare Part D payer-to-payer facilitation to match the transaction response to the transaction.						
Claim	391-MT	Patient Assignment Indicator (Direct Member Reimbursement Indicator)	Required if needed per trading partner agreement.						
Claim	995-E2	Route of Admission	Required if needed per trading partner agreement.						
Claim	996-G1	Compound Type	Required if needed per trading partner agreement.						
Claim	114-N4	Medicaid Subrogation internal Control Number/Transaction Control Number (ICN/TCN)	Required to report back on the response the claim number assigned by the Medicaid Agency.						
Claim	147-U7	Pharmacy Service Type	Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer see Appendix 28.1.9 of the version D.0 Telecommunication Standard Implementation guide for details.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Pharmacy Provider Segment	02		The Pharmacy Provider Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when a receiver needs pharmacy provider information to perform claim/encounter determination.						
Pharmacy Provide	465-EY	Provider ID Qualifier	value blank removed						
Prescriber Segment	03		The Prescriber Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when prescriber information is needed to perform claim/encounter determination. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.						
Prescriber	466-EZ	Prescriber ID Qualifier	value blank and 07 removed, 15 added						
Prescriber	467-1E	Prescriber Location Code	Removed in prior version						
Prescriber	468-2E	Prescriber Phone Number	value 00 and 07 removed, 15 added						
Prescriber	469-H5	Primary Provider Location Code	Removed in prior version						
Prescriber	364-2J	Primary Care Provider Last Name	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.						
Prescriber	365-2K	Primary Care Provider First Name	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.						
Prescriber	366-2M	Prescriber Street Address	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.						
Prescriber	367-2N	Prescriber City Address	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.						
Prescriber	368-2P	Prescriber State/Province Code	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
COB/0ther payments Segment	05		The Coordination of Benefits/Other Payments Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when a receiver needs payment information from other receivers to perform claim/encounter determination. This may be in the case of primary, secondary, tertiary et cetera health plan coverage for example. However the Coordination of Benefits/Other Payments Segment is mandatory for a Claim Billing or Encounter request to a downstream payer.						
COB/other payments	337-4C	Coordination of Benefits/Other Payments Count	maximum 9 occurrences recommended restriction of 3 or less was removed in D.0						
COB/other payme	338-5C	Other Payer Coverage Type	values 98 and 99 removed, 04 - 09 added						
COB/other payme	339-6C	Other Payer ID Qualifier	value 05 added, blank and 09 removed						
COB/other payments	993-A7	Internal Control Number	Required when used for payer-to-payer coordination of benefits to track the claim without regard to the "Service provider id, Prescription Number, & Date of Service".						
COB/other payments	341-HB	Other Payer Amount Paid Count	maximum 9 occurrences and the recommended limitation verbiage was removed in D.0						
COB/other payme	342-HC	Other Payer Amount Paid Qualifier	values blank, 08, 98, 99 removed						
COB/other payments	471-5E	Other Payer Reject Count	maximum 5 occurrences with D.0. Version 5.1 allowed a maximum of 20 with a recommended restriction of 5 or less.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
COB/other payments	472-6E	Other Payer Reject Code	values 1E,38,H5,RE,TE,and,UE removed, 201,2Ø2,2Ø3,2Ø4,2Ø5,2Ø6,2Ø7,2Ø8,2Ø9,21Ø,211,212, 213,214,215,216,217,218,219,22Ø,221,222,223,224,225 ,226,227,228,229,23Ø,231,232,233,234,235,236,237,23 8,239,24Ø,241,242,243,244,245,246,247,248,249,251,2 52,253,254,255,256,257,258,259,26Ø,261,262,263,264, 265,266,267,268,269,27Ø,271,272,273,274,275,276,277 ,278,279,28Ø,281,282,283,284,285,286,287,288,289,29 Ø,291,292,293,294,295,296,297,298,299,3ØØ,3Ø1,3Ø2, 3Ø3,3Ø4,3Ø5,3Ø6,3Ø7,3Ø8,3Ø9,31Ø,311,312,313,314,3 15,316,317,318,319,32Ø,321,322,323,324,325,326,327, 328,329,33Ø,331,332,333,334,335,336,337,338,339,34Ø ,341,342,343,344,345,346,347,348,349,35Ø,351,352,35 3,354,355,356,357,358,359,36Ø,361,363,364,365,366,3 67,368,369,37Ø,371,372,373,374,375,376,377,378,379, 38Ø,381,382,383,384,385,386,387,388,389,39Ø,391,392 ,393,394,395,396,397,398,399,4ØØ,4Ø1,4Ø2,4Ø3,4Ø4,4 Ø5,4Ø6,4Ø7,4Ø9,41Ø,411,412,413,414,415,416,417,418 ,419,42Ø,421,422,423,424,425,426,427,428,429,43Ø,43 1,432,433,434,435,436,437,438,439,44Ø,441,442,443,4 45,446,447,448,449,45Ø,451,452,453,454,455,456,457, 458,459,46Ø,461,462,463,1R,1S,1T,1U,1V,1W,1X,1Y,1Z, 2A,2B,2D,2G,2H,2J,2K,2M,2N,2P,2Q,2R,2S,2T,2U,2V,2W, 2X,2Z,2G,2H,2J,2K,2M,2N,2P,2Q,2R,2S,2T,2U,2V,2W,2X, 2Z,3Q,3U,3V,4B,4D,4G,4J,4K,4M,4N,4P,4Q,4R,4S,4T,4W, 4X,4Y,4Z,5J,6D,6G,6H,6J,6N,6P,6Q,6R,6S,6T,6U,6V,6W,6 X,6Z,7B,7D,7F,7G,7J,7K,7M,7N,7P,7Q,7R,7S,7T,7U,7V,7 W,7X,7Y,7Z,8A,8B,8D,8G,8H,8J,8K,8M,8N,8P,8Q,8R,8S,8 T,8U,8V,8W,8X,8Y,8Z,9B,9C,9D,9E,9G,9H,9J,9K,9M,9N,9 P,9Q,9R,9S,9T,9U,9V,9W,9X,9Y,9Z,A1,A2,A5,A6,A7,AQ,B A,BB,BC,BD,BF,BG,BH,BJ,BK,BM,E2,EH,G1,G2,G4,G5,G6, G7,G8,G9,HN,K5,MG,MH,MJ,MK,MM,MN,MP,MR,MT,M U,MV,MW,MX,MY,NA,NB,NC,NF,NG,NH,NJ,NK,NP,NQ,N R,NU,NV,NW,NX,NY,N1,N3,N4,N5,N6,N7,N8,N9,PQ,PU,P Ø,RL,RQ,RR,RV,RW,RX,RY,RZ,RØ,SØ,S1,S2,S3,S4,S5,S6,S7 ,S8,S9,SA,SB,SC,SD,SF,SG,SH,SJ,SK,SM,SN,SP,SQ,TD,TF,TG ,TH,TJ,TK,TM,TN,TQ,TR,TS,TT,TU,TV,TX,TY,TZ,TØ,T1,T2,T 3,T4,UA,UU,WØ,W5,W6,W7,W8,W9,XZ,X1,X2,X3,X4,X6, X7,X8,X9,YA,YB,YC,YD,YE,YF,YG,YH,YJ,YK,YM,YN,YP,YQ,Y R,YS,YT,YU,YW,YX,YY,YZ,YØ,Y1,Y2,Y3,Y4,Y5,Y6,Y7,Y8,Y9,Z Ø,Z1,Z2,Z3,Z4,Z5,Z6,Z7,Z8,Z9,ZA,ZB,ZC,ZD,ZK,ZM,ZN,ZP,Z Q,ZX,ZY,ZZ,UZ,UØ,U7,VA,VB,VC,VD,VE,VØ,ZD added						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
COB/other payments	353-NR	Other Payer-Patient Responsibility Amount Count	New - maximum 25 occurrences. Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. Note the occurrences are dependent upon the number of component parts returned from a previous payer.						
COB/other payments	351-NP	Other Payer-Patient Responsibility Amount Qualifier	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. Values 02,08, Ø9, 1Ø, 11, 12, and 13						
COB/other payments	352-NQ	Other Payer-Patient Responsibility Amount	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.						
COB/other payments	392-MU	Benefit Stage Count	New - maximum count 4. Required if Benefit Stage Amount (394-MW) is used.						
COB/other payments	393-MV	Benefit Stage Qualifier	Required if Benefit Stage Amount (394-MW) is used. Must only have one value per iteration - value must not be repeated.						
COB/other payments	394-MW	Benefit Stage Amount	Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefitstage specific financial amounts. Required if necessary for state/federal/regulatory agency programs.						
Workers Compensation Segment	06		The Workers' Compensation Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when processing a Claim Billing or Encounter for a work-related injury or condition.						
Workers Compens	318-CI	Employer State/Province Code	values YT,NT,NU,QC added, PQ removed						
Workers Compensation	117-TR	Billing Entity Type Indicator	This field is required for Rebill of claims or services and for Prior Authorization Request & Billing for claims and services.						
Workers Compens	118-TS	Pay-To Qualifier	Required if Pay To ID (119-TT) is used.						
Workers Compensation	119-TT	Pay-To ID	Required if transaction is submitted by a provider or agent, ut paid to another party.						
Workers Compensation	120-TU	Pay-To Name	Required if transaction is submitted by a provider or agent, ut paid to another party.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Workers Compensation	121-TV	Pay-To Street Address	Required if transaction is submitted by a provider or agent, but paid to another party.						
Workers Compensation	122-TW	Pay-To City Address	Required if transaction is submitted by a provider or agent, but paid to another party.						
Workers Compensation	123-TX	Pay-To State/Province Code	Required if transaction is submitted by a provider or agent, but paid to another party.						
Workers Compensation	124-TY	Pay-To Zip/Postal Code	Required if transaction is submitted by a provider or agent, but paid to another party.						
Workers Compensation	125-TZ	Generic Equivalent Product ID Qualifier	Required if Generic Equivalent Product ID (126-UA) is used.						
Workers Compensation	126-UA	Generic Equivalent Product ID	Required if necessary for state/federal/regulatory agency programs.						
DUR/PPS Segment	08		The DUR/PPS Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when a sender notifies the receiver of drug utilization, drug evaluations, or information on the appropriate selection to process the claim/encounter. The DUR/PPS information may be sent on the initial submission or alternatively sent after a DUR/PPS rejection from a receiver. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.						
DUR/PPS	473-7E	DUR/PPS Code Counter	maximum 9 occurrences supported and recommended verbiage has been removed in D.0						
DUR/PPS	439-E4	Reason for Service Code	values DR added, PC,SF,SR,SX,TD,TN and TP removed						
DUR/PPS	440-E5	Professional Service Code	values DP,MB,MP,PA,ZZ,AD,AN,AR,AT,CD,CH,CS,DA,DC,DD,DF, DI,DL,DM,DR,DS,ED,ER,EX,HD,IC,ID,LD,LK,LR,MC,MN,MS, MX,NA,NC,ND,NF,NN,NP,NR,NS,OH,PA,PC,PG,PN,PP,PR, PS,RE,RF,SC,SD,SE,SF,SR,SX added						
DUR/PPS	441-E6	Result of Service Code	value 4A added						
DUR/PPS	475-J9	DUR CO-Agent ID Qualifier	values blank & 13 removed, 27 - 33, 35, 37 added						
Pricing	478-H7	Other Amount Claimed Submitted Count	maximum 3 occurrences with D.0 version 5.1 had a maximum of 9 recommended 3 occurrences or less.						
Pricing	479-H8	Other Amount Claimed Submitted Qualifier	value blank removed and 09 added						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Pricing	423-DN	Basis of Cost Determination	value blank removed and 08, 10 - 13 added						
Pricing	113-N3	Medicaid Paid Amount	Required if affects pricing in Medicaid Subrogation (contains the amount paid to the pharmacy).						
Coupon Segment	09		The Coupon Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when the sender seeks reimbursement for a claim billing which includes a fixed amount or percentage of total price reduction. It is used in situations where the coupon is applied to the transaction.						
Coupon	485-KE	Coupon Type	value blank removed						
Compound Segment	10		The Compound Segment changed from optional to situational for a Claim Billing or Encounter request. It is used for multi-ingredient prescriptions, when each ingredient is reported. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.						
Compound	452-EH	Compound route of Administration	Removed in prior version						
Compound	447-EC	Compound Route of Administration	maximum 25 ingredients in D.0 version 5.1 had maximum at 99 with 25 as recommended.						
Compound	488-RE	Compound Ingredient Component Count	values blank, 05, and 13 removed, 15, 28 - 33 added						
Compound	490-UE	Compound Ingredient Drug Cost	values 00, 08, 10 - 12 added; blank removed						
Compound	362-2G	Compound Ingredient Basis of Cost Determination	Required when Compound Ingredient Modifier Code (363-2H) is sent. Maximum count of 10.						
Compound	363-2H	Compound Ingredient Modifier Code Count	Required if necessary for state/federal/regulatory agency programs.						
Clinical Segment	13		The Clinical Segment changed from optional to situational for a Claim Billing or Encounter request. It is used to specify diagnosis information associated with the Claim Billing or Encounter transaction. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.						
Clinical	491-VE	Diagnosis Code Count	maximum 5 occurrences with D.0 version 5.1 had maximum at 9 with 5 as recommended.						
Clinical	492-WE	Diagnosis Code Qualifier	values 08 and 09 added; blank removed						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Clinical	493-XE	Clinical Information Counter	maximum 5 occurrences in D.0 version 5.1 allowed a maximum of 9 with 5 or less recommended.						
Clinical	496-H2	Measurement Dimension	values 18 - 34 added						
Clinical	497-H3	Measurement Unit	values 19 - 27 added						
Additional Documentation Segment	14		New - The Additional Documentation Segment is situational for Claim Billing or Encounter request. It is used to provide additional information on Medicare forms.						
Additional Documentation	369-2Q	Additional Documentation Type ID	Unique identifier for the data being submitted. Values 001-015						
Additional Documentation	374-2V	Request Period Begin Date	Required if necessary for state/federal/regulatory agency programs.						
Additional Documentation	375-2W	Request Period Recert/Revised Date	Required if necessary for state/federal/regulatory agency programs. Required if the Request Status (373-2U) = “2” (Revision) or “3” (Recertification).						
Additional Documentation	373-2U	Request Status	Required if necessary for state/federal/regulatory agency programs.						
Additional Docum	371-2S	Length of Need Qualifier	Required if Length of Need (370-2R) is used.						
Additional Documentation	370-2R	Length of Need	Required if necessary for state/federal/regulatory agency programs.						
Additional Documentation	372-2T	Prescriber/Supplier Date Signed	Required if necessary for state/federal/regulatory agency programs.						
Additional Documentation	376-2X	Supporting Documentation	Required if necessary for state/federal/regulatory agency programs (using Section C of Medicare’s CMN forms).						
Additional Documentation	377-2Z	Question Number/Letter Count	New - maximum 50 occurrences. Required if needed to provide response to narratives.						
Additional Documentation	378-4B	Question Number/Letter	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form. Required if Question Number/Letter Count (377-2Z) is greater than 0.						
Additional Documentation	379-4D	Question Percent Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Additional Documentation	380-4G	Question Date Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Additional Documentation	381-4H	Question Dollar Amount Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Additional Documentation	382-4J	Question Numeric Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Additional Documentation	383-4K	Question Alphabetic Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Facility Segment	15		The Facility Segment is situational for Claim Billing or Encounter request. It is used when these fields could result in different coverage,pricing, patient financial responsibility, and/or drug utilization review outcome.						
Facility	385-3Q	Facility Name	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.						
Facility	386-3U	Facility Street Address	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.						
Facility	388-5J	Facility City Address	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.						
Facility	387-3V	Facility State/Province Code	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.						
Facility	389-6D	Facility Zip/Postal Code	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.						
Narrative Segment	16		Segment requirement changed from optional to not used for all transaction types checked.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Narrative	390-BM	Narrative Message	The Narrative Segment is situational for Claim Billing or Encounter request. It is used to support exception handling of pharmacy claims for Medicare claim billing.						
Response Header	103-A3	Transaction Code	B1 & field 455-EM=1 for RX Billing						
Response Header	202-B2	Service Provider ID Qualifier	00 removed, 15 and 16 added						
Response Insurance	115-N5	Medicaid ID Number	Required, if known, when patient has Medicaid coverage. Required when used for payer-to-payer coordination of benefits to track the claim without regard to the “Service Provider ID, Prescription Number, & Date of Service”.						
Response Insuranc	116-N6	Medicaid Agency Number	Required to identify the Medicaid agency.						
Response Patient Segment	29		New Segment added with D.0. This segment is used for Medicare Part D Eligibility transactions to provide patient name and date of birth in order to provide additional patient information. This information could assist in the verification that the eligibility information returned is indeed the patient for which the eligibility request was intended.This segment can be sent response/transaction types except for when the response is transmission rejected/transaction rejected.						
Response Status	112-AN	Transaction Response Status	value B added						
Response Status	510-FA	Reject Count	maximum 5 occurrences in D.0 version 5.1 allowed a maximum of 99 with 5 or less recommended.						
Response Status	511-FB	Reject Code	values 1E,38,H5,RE,TE,and,UE removed,201,2Ø2,2Ø3,2Ø4,2Ø5,2Ø6,2Ø7,2Ø8,2Ø9,21Ø,211,212,213,214,215,216,217,218,219,22Ø,221,222,223,224,225,226,227,228,229,23Ø,231,232,233,234,235,236,237,238,239,24Ø,241,242,243,244,245,246,247,248,249,251,252,253,254,25						
Response Status	547-5F	Approved Message Code Count	maximum 5 occurrences in D.0 version 5.1 had a maximum of 9 with 5 or less recommended.						
Response Status	548-6F	Approved Message Code	Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. This field repeats the number of times indicated in field 547-5f.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Status	130-UF	Additional Message Information Count	Required if Additional Message Information (526-FQ) is used. Used to qualify the number of occurrences of the Additional Message Information (526-FQ) that is included in the Response Status Segment. Maximum number of occurences is 25.						
Response Status	132-UH	Additional Message Information Qualifier	Required if Additional Message Information (526-FQ) is used.						
Response Status	**526-FQ**	**Additional Message Information**	**field length reduced from 200 to 40 bytes and added repeat functionality**						
Response Status	131-UG	Additional Message Information Continuity	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.						
Response Status	549-7F	Help Desk Phone Number Qualifier	value blank removed						
Response Status	993-A7	Internal Control Number	Required when used for payer-to-payer coordination of benefits to track the claim without regard to the "Service provider id, Prescription Number, & Date of Service".						
Response Status	987-MA	URL	Provided for informational purposes only to relay healthcare communications via the Internet.						
Response Claim	**402-D2**	**Prescription/Service Reference Number**	**field lengthened from 7 to 12 bytes**						
Response Claim	551-9F	Preferred Product Count	maximum 6 occurrences in D.0 version 5.1 allowed maximum of 9 with 6 or less recommended.						
Response Claim	552-AP	Preferred Product ID Qualifier	values blank, 5, and 13 removed, 28 - 33, 37 added						
Response Claim	114-N4	Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)	Required to report back on the response the claim number assigned by the Medicaid Agency.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Pricing Segment	23		Segment requirement changed from optional to situational. The Response Pricing Segment is situational for a Service Billing Response when the Header Response Status (501-F1) of "A" (Accepted) and Transaction Response Status (112-AN) is “C” (Captured) or “Q” (Duplicate of Captured). The Response Pricing Segment is not used in payer-to-payer transactions. All dollar fields except Patient Pay Amount (505-F5) are estimated amounts. If actual amounts are returned on fields other than Patient Pay Amount (505-F5), the “P” (Paid) response must be used. If the Transaction Response Status (112-AN) = C (Captured) or Q (Duplicate of Captured), dollar fields should be supplied in the response.						
Response Pricing	557-AV	Tax Exempt Indicator	value 2 removed, 3 and 4 added						
Response Pricing	561-AZ	Percentage Sales Tax Basis Paid	01 removed						
Response Pricing	563-J2	Other Amount Paid Count	maximum 3 occurrences in D.0 version 5.1 allowed maximum of 9 with 3 or less recommended.						
Response Pricing	564-J3	Other Amount Paid Qualifier	value blank removed and 09 was added						
Response Pricing	522-FM	Basis of Reimbursement Determination	values 10 - 17 added						
Response Pricing	519-FJ	Amount Attributed To Product Selection	Removed in prior version						
Response Pricing	346-HH	Amount Exceeding Periodic Benefit Maximum	values blank and 00 removed						
Response Pricing	347-HJ	Basis of Calculation-Dispensing Fee	values blank and 00 removed						
Response Pricing	571-NZ	Basis of Calculation-Percentage Sales Tax	Required if the customer is responsible for 100% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay.						
Response Pricing	575-EQ	Amount Attributed to Processor Fee	Used when necessary to identify the Patient’s portion of the Sales Tax. Provided for informational purposes only.						
Response Pricing	574-2Y	Patient Sales Tax Amount	Used when necessary to identify the Plan’s portion of the Sales Tax. Provided for informational purposes only.						
Response Pricing	572-4U	Plan Sales Tax Amount	Required if Patient Pay Amount (5Ø5-F5) includes coinsurance as patient financial responsibility.						
Response Pricing	573-4V	Amount of Coinsurance	Required if Dispensing Status (343-HD) on submission is “P” (Partial Fill) or “C” (Completion of Partial Fill).						
Response Pricing	392-MU	Basis of Calculation-Coinsurance	New - maximum 3 occurrences. Required if Benefit Stage Amount (394-MW) is used.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Pricing	393-MV	Benefit Stage Count	Required if Benefit Stage Amount (394-MW) is used. Must only have one value per iteration - value must not be repeated.						
Response Pricing	394-MW	Benefit Stage Qualifier	Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs.						
Response Pricing	577-G3	Benefit Stage Amount	This information should be provided when a patient selected the brand drug and a generic form of the drug was available. It will contain an estimate of the difference between the cost of the brand drug and the generic drug, when the brand drug is more expensive than the generic. It is information that the provider should provide to the patient.						
Response Pricing	128-UC	Estimated Generic Savings	This dollar amount will be provided, if known, to the receiver when the transaction had spending account dollars reported as part of the patient pay amount. This field is informational only. It is reported back to the provider and the patient the amount remaining on the spending account after the current claim updated the spending account.						
Response Pricing	129-UD	Spending Account Amount Remaining	Required when the patient meets the plan-funded assistance criteria, to reduce Patient Pay Amount (5Ø5-F5). The resulting Patient Pay Amount (5Ø5-F5) must be greater than or equal to zero. This field is always a negative amount or zero.						
Response Pricing	133-UJ	Health Plan-Funded Assistance Amount	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another.						
Response Pricing	134-UK	Amount Attributed to Provider Network Selection	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand drug.						
Response Pricing	135-UM	Amount Attributed to Product Selection/Brand Drug	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a nonpreferred formulary product.						
Response Pricing	136-UN	Amount Attributed to Product Selection/Non-Preferred Formulary Selection	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand non-preferred formulary product.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Pricing	137-UP	Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection	Required when the patient's financial responsibility is due to the coverage gap.						
Response Pricing	148-U8	Amount Contributed to Coverage Gap	Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency. This field is informational only.						
Response Pricing	149-U9	Ingredient Cost Contracted/Reimbursable Amount	Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15"(Patient Pay Amount) unless prohibited by state/federal/regulatory agency. This field is informational only.						
Response DUR/PPS	567-J6	DUR/PPS Response Code Qualifier	maximum 9 occurrences removed the recommended verbiage with D.0						
Response DUR/PP	439-E4	Reason for Service Code	Values DR and UD added						
Response DUR/PP	528-FS	Clinical Significance Code	value 9 added						
Response DUR/PP	532-FW	Database Indicator	value blanks removed, 6 and 7 added						
Response COB/other payments Segment	28		New segment added with D.0 - The Response Coordination of Benefits/Other Payers Segment is situational for a Service Billing response when the Header Response Status (5Ø1-F1) of "A" (Accepted) and Transaction Response Status (112-AN) of "P" (Paid) or "D" (Duplicate of Paid) when other insurance information is available for coordination of benefits. If subsequent payer(s) for this patient is not known, the Other Payer information\ is not sent.						
Response Coordination of	355-NT	Other Payer ID Count	New - maximum 3 occurrences. Count of other payers with payment responsibility.						
Response Coordin	338-5C	Other Payer Coverage Type	values 04 - 09 added, 98 and 99 removed						
Response Coordin	339-6C	Other Payer ID Qualifier	values 05 added, 09 removed						
Response Coordination of	991-MH	Other Payer Processor Control Number	Required if other insurance information is available for coordination of benefits.						
Response Coordination of	356-NU	Other Payer Cardholder ID	Required if other insurance information is available for coordination of benefits.						
Response Coordination of	992-MJ	Other Payer Group Id	Required if other insurance information is available for coordination of benefits.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Coordination of Benefits/Other	142-UV	Other Payer Person Code	Required if needed to uniquely identify the family members within the CardholderID, as assigned by the other payer.						
Response Coordination of	127-UB	Other Payer Help Desk Phone Number	Required if needed to provide a support telephone number f the other payer to the receiver.						
Response Coordination of Benefits/Other	143-UW	Other Payer Patient Relationship Code	Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer.						
Response Coordination of	144-UX	Other Payer Benefit Effective Date	Required when other coverage is known which is after the Date of Service submitted.						
Response Coordination of	145-UY	Other Payer Benefit Termination Date	Required when other coverage is known which is after the Date of Service submitted.						

NCPDP D.0
BILLING
SIZE CHANGE REPORT

NCPDP D.0 Billing Gap Analysis
Size Changes

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Claim	402-D2	Prescription/Service Reference Number	field lengthened from 7 to 12 bytes
Claim	456-EN	Associated Prescription/Service Date Qualifier	field lengthened from 7 to 12 bytes
Response Status	526-FQ	Additional Message Information	field length reduced from 200 to 40 bytes and added repeat functionality
Response Claim	402-D2	Prescription/Service Reference Number	field lengthened from 7 to 12 bytes

NCPDP D.0
BILLING
USE CHANGE REPORT

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Patient Segment	01		The Patient Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when a receiver needs some of the patient demographic information to perform eligibility and claim/encounter determination. The Patient Segment must be submitted when needed to differentiate between the patient and the cardholder. If the cardholder and the patient are the same, then the Patient Segment is not submitted unless additional information about the patient is needed to clarify the claim/encounter determination. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.
Claim	458-SE	Procedure Modifier Code Count	maximum occurrences increased to 10 removed the recommend number of occurrences with D.0, field lengthened from 1 to 2 bytes
Pharmacy Provider Segment	02		The Pharmacy Provider Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when a receiver needs pharmacy provider information to perform claim/encounter determination.

Segment	Field	Description	D.0 Change Comment
Prescriber Segment	03		The Prescriber Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when prescriber information is needed to perform claim/encounter determination. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.
COB/0ther payments Segment	05		The Coordination of Benefits/Other Payments Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when a receiver needs payment information from other receivers to perform claim/encounter determination. This may be in the case of primary, secondary, tertiary et cetera health plan coverage for example. However the Coordination of Benefits/Other Payments Segment is mandatory for a Claim Billing or Encounter request to a downstream payer.
COB/other payments	337-4C	Coordination of Benefits/Other Payments Count	maximum 9 occurrences recommended restriction of 3 or less was removed in D.0
COB/other payments	341-HB	Other Payer Amount Paid Count	maximum 9 occurrences and the recommended limitation verbiage was removed in D.0
COB/other payments	471-5E	Other Payer Reject Count	maximum 5 occurrences with D.0. Version 5.1 allowed a maximum of 20 with a recommended restriction of 5 or less.
Workers Compensation Segment	06		The Workers' Compensation Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when processing a Claim Billing or Encounter for a work-related injury or condition.

Segment	Field	Description	D.0 Change Comment
DUR/PPS Segment	08		The DUR/PPS Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when a sender notifies the receiver of drug utilization, drug evaluations, or information on the appropriate selection to process the claim/encounter. The DUR/PPS information may be sent on the initial submission or alternatively sent after a DUR/PPS rejection from a receiver. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.
DUR/PPS	473-7E	DUR/PPS Code Counter	maximum 9 occurrences supported and recommended verbiage has been removed in D.0
Pricing	478-H7	Other Amount Claimed Submitted Count	maximum 3 occurrences with D.0 version 5.1 had a maximum of 9 recommended 3 occurrences or less.
Coupon Segment	09		The Coupon Segment changed from optional to situational for a Claim Billing or Encounter request. It is used when the sender seeks reimbursement for a claim billing which includes a fixed amount or percentage of total price reduction. It is used in situations where the coupon is applied to the transaction.
Compound Segment	10		The Compound Segment changed from optional to situational for a Claim Billing or Encounter request. It is used for multi-ingredient prescriptions, when each ingredient is reported. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.
Compound	447-EC	Compound Route of Administration	maximum 25 ingredients in D.0 version 5.1 had maximum at 99 with 25 as recommended.

Segment	Field	Description	D.0 Change Comment
Clinical Segment	13		The Clinical Segment changed from optional to situational for a Claim Billing or Encounter request. It is used to specify diagnosis information associated with the Claim Billing or Encounter transaction. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.
Clinical	491-VE	Diagnosis Code Count	maximum 5 occurrences with D.0 version 5.1 had maximum at 9 with 5 as recommended.
Clinical	493-XE	Clinical Information Counter	maximum 5 occurrences in D.0 version 5.1 allowed a maximum of 9 with 5 or less recommended.
Response Status	510-FA	Reject Count	maximum 5 occurrences in D.0 version 5.1 allowed a maximum of 99 with 5 or less recommended.
Response Status	547-5F	Approved Message Code Count	maximum 5 occurrences in D.0 version 5.1 had a maximum of 9 with 5 or less recommended.
Response Status	526-FQ	Additional Message Information	field length reduced from 200 to 40 bytes and added repeat functionality
Response Claim	551-9F	Preferred Product Count	maximum 6 occurrences in D.0 version 5.1 allowed maximum of 9 with 6 or less recommended.
Response Pricing Segment	23		Segment requirement changed from optional to situational. The Response Pricing Segment is situational for a Service Billing Response when the Header Response Status (501-F1) of "A" (Accepted) and Transaction Response Status (112-AN) is “C” (Captured) or “Q” (Duplicate of Captured). The Response Pricing Segment is not used in payer-to-payer transactions. All dollar fields except Patient Pay Amount (505-F5) are estimated amounts. If actual amounts are returned on fields other than Patient Pay Amount (505-F5), the “P” (Paid) response must be used. If the Transaction Response Status (112-AN) = C (Captured) or Q (Duplicate of Captured), dollar fields should be supplied in the response.

Segment	Field	Description	D.0 Change Comment
Response Pricing	563-J2	Other Amount Paid Count	maximum 3 occurrences in D.0 version 5.1 allowed maximum of 9 with 3 or less recommended.
Response DUR/PPS	567-J6	DUR/PPS Response Code Qualifier	maximum 9 occurrences removed the recommended verbiage with D.0
Response COB/other payments Segment	28		New segment added with D.0 - The Response Coordination of Benefits/Other Payers Segment is situational for a Service Billing response when the Header Response Status (5Ø1-F1) of "A" (Accepted) and Transaction Response Status (112-AN) of “P” (Paid) or “D” (Duplicate of Paid) when other insurance information is available for coordination of benefits. If subsequent payer(s) for this patient is not known, the Other Payer information\ is not sent.

NCPDP D.0
BILLING REVERSAL
NEW CONTENT REPORT

emdeon

NCPDP D.0 Billing Reversal Gap Analysis
New Content

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Insurance	359-2A	Medigap ID	Required, if known, when patient has Medigap coverage.
Claim	147-U7	Pharmacy Service Type	Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer see Appendix 28.1.9 of the version D.0 Telecommunication Standard Implementation guide for details.
Response Status	130-UF	Additional Message Information Count	Required if Additional Message Information (526-FQ) is used. Used to qualify the number of occurrences of the Additional Message Information (526-FQ) that is included in the Response Status Segment. Maximum number of occurences is 25.
Response Status	132-UH	Additional Message Information Qualifier	Required if Additional Message Information (526-FQ) is used.
Response Status	131-UG	Additional Message Information Continuity	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.
Response Status	993-A7	Internal Control Number	Required when used for payer-to-payer coordination of benefits to track the claim without regard to the “Service provider id, Prescription Number, & Date of Service”.

NCPDP D.0
BILLING REVERAL
DELETED CONTENT REPORT

No Deleted Content to Report

NCPDP D.0
BILLING REVERSAL
CODE CHANGES REPORT

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NCPDP D.0 Billing Reversal Gap Analysis
Code Changes

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Header	102-A2	Version/Release Number	Version release changed from 5.1 to D.0
Header	103-A3	Transaction Code	Value B2 with field 455-EM qualifed with a 1 for Rx Billing.
Header	202-B2	Service Provider ID Qualifier	0Ø removed, 15 and 16 added
Claim	455-EM	Prescription/Service Reference Number Qualifier	value blank removed. For a reversal of a B2 transaction this field should be filled with a '1' for Rx Billing.
Claim	436-E1	Product/Service ID Qualifier	value blank, 05, and 13 removed, values 15, 27 - 34 added. Must contain the product/Service ID Qualifier (436-E1) value from the original Billing.
Claim	308-C8	Other Coverage Code	Values: Modify definition: 8 = Claim is billing for patient financial responsibility only; 3=Other Coverage Billed – claim not covered; 0= Not specified by patient. Values 05, 06, 07 removed. This field is required if needed by the receiver to match the claim that is being reversed.
COB/other payments	338-5C	Other Payer Coverage Type	values 98 and 99 removed, 04 - 09 added
DUR/PPS	439-E4	Reason for Service Code	values DR added, PC,SF,SR,SX,TD,TN and TP removed. Required if this field is needed to report drug utilization review outcome.
DUR/PPS	440-E5	Professional Service Code	values DP,MB,MP,PA,ZZ,AD,AN,AR,AT,CD,CH,CS,DA,DC,DD,DF,DI,DL,DM,DR,DS,ED,ER,EX,HD,IC,ID,LD,LK,LR,MC,MN,MS,MX,NA,NC,ND,NF,NN,NP,NR,NS,OH,PA,PC,PG,PN,PP,PR,PS,RE,RF,SC,SD,SE,SF,SR,SX added. Required if this field is needed to report drug utilization review outcome.

Segment	Field	Description	D.0 Change Comment
DUR/PPS	441-E6	Result of Service Code	value 4A added. Required if this field is needed to report drug utilization review outcome.
Response Header	103-A3	Transaction Code	Value is B2 with field 455-Em=1 for Rx Billing.
Response Header	202-B2	Service Provider ID Qualifier	00 removed, 15 and 16 added
Response Status	112-AN	Transaction Response Status	value B added
Response Status	511-FB	Reject Code	values 1E,38,H5,RE,TE,and,UE removed,201,2Ø2,2Ø3,2Ø4,2Ø5,2Ø6,2Ø7,2Ø8,2Ø9,21Ø,211,212,213,214,215,216,217,218,219,22Ø,221,222,223,224,225,226,227,228,229,23Ø,231,232,233,234,235,236,237,238,239,24Ø,241,242,243,244,245,246,247,248,249,251,252,253,254,25
Response Status	549-7F	Help Desk Phone Number Qualifier	value blank removed. Required if Help Desk Phone Number in field 550-8f is used.

NCPDP D.0
BILLING REVERSAL
USE CHANGES REPORT

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NCPDP D.0 Billing Reversal Gap Analysis
Use Changes

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
COB/other payments	337-4C	Coordination of Benefits/Other Payments Count	maximum 9 occurrences recommended restriction of 3 or less was removed in D.0
DUR/PPS	473-7E	DUR/PPS Code Counter	maximum 9 occurrences supported and recommended verbiage has been removed in D.0. This field is required if the DUR/PPS Segment is used.
Response Status	510-FA	Reject Count	maximum 5 occurrences in D.0 version 5.1 allowed a maximum of 99 with 5 or less recommended.
Response Status	526-FQ	Additional Message Information	field length reduced from 200 to 40 bytes and added repeat functionality. This field may contain continuing data from field 504-F4 when there is a single transaction other wise it will contain transaction level text.
Response Pricing Segment	23		Segment requirement changed from optional or situational. The segment is only sent when transmission is accepted/transaction approved otherwise do not send.

NCPDP D.0
BILLING REVERSAL
SIZE CHANGES REPORT

NCPDP D.0 Billing Reversal Gap Analysis
Size Changes

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Claim	402-D2	Prescription/Service Reference Number	field lengthened from 7 to 12 bytes
Response Status	526-FQ	Additional Message Information	field length reduced from 200 to 40 bytes and added repeat functionality. This field may contain continuing data from field 504-F4 when there is a single transaction other wise it will contain transaction level text.
Response Claim	402-D2	Prescription/Service Reference Number	field lengthened from 7 to 12 bytes. If there were significant digits submited on the submission they must also be returned on the response.

NCPDP D.0
BILLING REVERSAL
OVERALL CHANGE REPORT

Items in Red are flagged as Transitions Challenges

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Header	102-A2	Version/Release Number	Version release changed from 5.1 to D.0						
Header	103-A3	Transaction Code	Value B2 with field 455-EM qualifed with a 1 for Rx Billing.						
Header	202-B2	Service Provider ID Qualifier	0Ø removed, 15 and 16 added						
Insurance	359-2A	Medigap ID	Required, if known, when patient has Medigap coverage.						
Claim	455-EM	Prescription/Service Reference Number Qualifier	value blank removed. For a reversal of a B2 transaction this field should be filled with a '1' for Rx Billing.						
Claim	**402-D2**	**Prescription/Service Reference Number**	**field lengthened from 7 to 12 bytes**						
Claim	436-E1	Product/Service ID Qualifier	value blank, 05, and 13 removed, values 15, 27 - 34 added. Must contain the product/Service ID Qualifier (436-E1) value from the original Billing.						
Claim	308-C8	Other Coverage Code	Values: Modify definition: 8 = Claim is billing for patient financial responsibility only; 3=Other Coverage Billed – claim not covered; 0= Not specified by patient. Values 05, 06, 07 removed. This field is required if needed by the receiver to match the claim that is being reversed.						
Claim	147-U7	Pharmacy Service Type	Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer see Appendix 28.1.9 of the version D.0 Telecommunication Standard Implementation guide for details.						
COB/other payments	337-4C	Coordination of Benefits/Other Payments Count	maximum 9 occurrences recommended restriction of 3 or less was removed in D.0						
COB/other payme	338-5C	Other Payer Coverage Type	values 98 and 99 removed, 04 - 09 added						
DUR/PPS	473-7E	DUR/PPS Code Counter	maximum 9 occurrences supported and recommended verbiage has been removed in D.0. This field is required if the DUR/PPS Segment is used.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
DUR/PPS	439-E4	Reason for Service Code	values DR added, PC,SF,SR,SX,TD,TN and TP removed. Required if this field is needed to report drug utilization review outcome.						
DUR/PPS	440-E5	Professional Service Code	values DP,MB,MP,PA,ZZ,AD,AN,AR,AT,CD,CH,CS,DA,DC,DD,DF, DI,DL,DM,DR,DS,ED,ER,EX,HD,IC,ID,LD,LK,LR,MC,MN,MS, MX,NA,NC,ND,NF,NN,NP,NR,NS,OH,PA,PC,PG,PN,PP,PR, PS,RE,RF,SC,SD,SE,SF,SR,SX added. Required if this field is needed to report drug utilization review outcome.						
DUR/PPS	441-E6	Result of Service Code	value 4A added. Required if this field is needed to report drug utilization review outcome.						
Response Header	103-A3	Transaction Code	Value is B2 with field 455-Em=1 for Rx Billing.						
Response Header	202-B2	Service Provider ID Qualifier	00 removed, 15 and 16 added						
Response Status	112-AN	Transaction Response Status	value B added						
Response Status	510-FA	Reject Count	maximum 5 occurrences in D.0 version 5.1 allowed a maximum of 99 with 5 or less recommended.						
Response Status	511-FB	Reject Code	values 1E,38,H5,RE,TE,and,UE removed,201,2Ø2,2Ø3,2Ø4,2Ø5,2Ø6,2Ø7,2Ø8,2Ø9,21Ø, 211,212,213,214,215,216,217,218,219,22Ø,221,222,223 ,224,225,226,227,228,229,23Ø,231,232,233,234,235,23 6,237,238,239,24Ø,241,242,243,244,245,246,247,248,2 49,251,252,253,254,25						
Response Status	130-UF	Additional Message Information Count	Required if Additional Message Information (526-FQ) is used. Used to qualify the number of occurrences of the Additional Message Information (526-FQ) that is included in the Response Status Segment. Maximum number of occurences is 25.						
Response Status	132-UH	Additional Message Information Qualifier	Required if Additional Message Information (526-FQ) is used.						
Response Status	**526-FQ**	**Additional Message Information**	**field length reduced from 200 to 40 bytes and added repeat functionality. This field may contain continuing data from field 504-F4 when there is a single transaction other wise it will contain transaction level text.**						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Status	131-UG	Additional Message Information Continuity	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.						
Response Status	549-7F	Help Desk Phone Number Qualifier	value blank removed. Required if Help Desk Phone Number in field 550-8f is used.						
Response Status	993-A7	Internal Control Number	Required when used for payer-to-payer coordination of benefits to track the claim without regard to the "Service provider id, Prescription Number, & Date of Service".						
Response Claim	**402-D2**	**Prescription/Service Reference Number**	**field lengthened from 7 to 12 bytes. If there were significant digits submited on the submission they must also be returned on the response.**						
Response Pricing Segment	23		Segment requirement changed from optional or situational. The segment is only sent when transmission is accepted/transaction approved otherwise do not send.						

NCPDP D.0
BILLING RE-BILL
DELETED CONTENT REPORT

NCPDP D.0 Billing Re-Bill Gap Analysis
Deleted Content

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Prescriber	467-1E	Prescriber Location Code	Removed in prior version
Prescriber	469-H5	Primary Provider Location Code	Removed in prior version
Compound	452-EH	Compound route of Administration	Removed in prior version
Response Pricing	519-FJ	Amount Attributed To Product Selection	Removed in prior version

NCPDP D.0
BILLING RE-BILL
CODE CHANGES REPORT

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NCPDP D.0 Billing Re-Bill Gap Analysis
Code Changes

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Header	102-A2	Version/Release Number	Version release changed from 5.1 to D.0
Header	103-A3	Transaction Code	Value = B3 and field 455-EM must be ewual to '1' for Rx Billing.
Header	202-B2	Service Provider ID Qualifier	00 removed, 15 and 16 added
Patient	331-CX	Patient ID Qualifier	value blank removed, 04 - 11, 1J, EA added. Required when 332-CY is submitted.
Patient	324-CO	Patient State/Province Code	values YT,NT,NU,QC added, PQ removed
Patient	307-C7	Place of Service	values 02 and 09 removed; 12 - 16, 20 - 26, 31 - 34, 41, 42, 49 - 57,60 - 62, 65, 71, 72, 81, 99 added. Required if this field could result in different coverage, pricing, or patient financial responsibility.
Claim	455-EM	Prescription/Service Reference Number Qualifier	value blank removed
Claim	436-E1	Product/Service ID Qualifier	value blank, 05, and 13 removed, values 15, 27 - 34 added. If billing for a multi-ingredient prescription, Product/Service ID Qualifier (436-E1) is zero (“00”).
Claim	459-ER	Procedure Modifier Code	Please check the referenced CMS web site referenced in the 5.1 & D.0 code values columns for the latest list of codes. Required to define a further level of specificity if the Product/Service ID (4Ø7-D7) indicated a Procedure Code was submitted. Required if this field could result in different coverage, pricing, or patient financial responsibility. Occurs the number of times identified in Procedure Modifier Code Count (458-SE).

Segment	Field	Description	D.0 Change Comment
Claim	419-DJ	Prescription Origin Code	value 5 added
Claim	420-DK	Submission Clarification Code	values 00, 10 through 19 added
Claim	308-C8	Other Coverage Code	Values: Modify definition: 8 = Claim is billing for patient financial responsibility only; 3=Other Coverage Billed – claim not covered; Ø= Not specified by patient. Values 05, 06, 07 removed
Claim	429-DT	Special Packaging Indicator	values 4 and 5 added
Claim	453-EJ	Original Prescribed Product/Service ID Qualifier	values blank, 05, and 13 removed and 15, 28 - 33 added
Claim	461-EU	Prior Authorization Type Code	value 09 added. Also note that the definition for value 04 changed to, 'Exemption from Copay and/or Coinsurance'.
Claim	343-HD	Dispensing Status	value blank removed. Required for the partial fill or the completion fill of a prescription.
Pharmacy Provider	465-EY	Provider ID Qualifier	value blank removed
Prescriber	466-EZ	Prescriber ID Qualifier	value blank and 07 removed, 15 added
Prescriber	468-2E	Prescriber Phone Number	value 00 and 07 removed, 15 added
COB/other payments	338-5C	Other Payer Coverage Type	values 98 and 99 removed, 04 - 09 added
COB/other payments	339-6C	Other Payer ID Qualifier	value 05 added, blank and 09 removed
COB/other payments	342-HC	Other Payer Amount Paid Qualifier	values blank, 08, 98, 99 removed

Segment	Field	Description	D.0 Change Comment
COB/other payments	472-6E	Other Payer Reject Code	values 1E,38,H5,RE,TE,and,UE removed, 201,2Ø2,2Ø3,2Ø4,2Ø5,2Ø6,2Ø7,2Ø8,2Ø9,21Ø,211,212, 213,214,215,216,217,218,219,22Ø,221,222,223,224,225 ,226,227,228,229,23Ø,231,232,233,234,235,236,237,23 8,239,24Ø,241,242,243,244,245,246,247,248,249,251,2 52,253,254,255,256,257,258,259,26Ø,261,262,263,264, 265,266,267,268,269,27Ø,271,272,273,274,275,276,277 ,278,279,28Ø,281,282,283,284,285,286,287,288,289,29 Ø,291,292,293,294,295,296,297,298,299,3ØØ,3Ø1,3Ø2, 3Ø3,3Ø4,3Ø5,3Ø6,3Ø7,3Ø8,3Ø9,31Ø,311,312,313,314,3 15,316,317,318,319,32Ø,321,322,323,324,325,326,327, 328,329,33Ø,331,332,333,334,335,336,337,338,339,34Ø ,341,342,343,344,345,346,347,348,349,35Ø,351,352,35 3,354,355,356,357,358,359,36Ø,361,363,364,365,366,3 67,368,369,37Ø,371,372,373,374,375,376,377,378,379, 38Ø,381,382,383,384,385,386,387,388,389,39Ø,391,392 ,393,394,395,396,397,398,399,4ØØ,4Ø1,4Ø2,4Ø3,4Ø4,4 Ø5,4Ø6,4Ø7,4Ø9,41Ø,411,412,413,414,415,416,417,418 ,419,42Ø,421,422,423,424,425,426,427,428,429,43Ø,43 1,432,433,434,435,436,437,438,439,44Ø,441,442,443,4 45,446,447,448,449,45Ø,451,452,453,454,455,456,457, 458,459,46Ø,461,462,463,1R,1S,1T,1U,1V,1W,1X,1Y,1Z, 2A,2B,2D,2G,2H,2J,2K,2M,2N,2P,2Q,2R,2S,2T,2U,2V,2W, 2X,2Z,2G,2H,2J,2K,2M,2N,2P,2Q,2R,2S,2T,2U,2V,2W,2X, 2Z,3Q,3U,3V,4B,4D,4G,4J,4K,4M,4N,4P,4Q,4R,4S,4T,4W, 4X,4Y,4Z,5J,6D,6G,6H,6J,6N,6P,6Q,6R,6S,6T,6U,6V,6W,6 X,6Z,7B,7D,7F,7G,7J,7K,7M,7N,7P,7Q,7R,7S,7T,7U,7V,7 W,7X,7Y,7Z,8A,8B,8D,8G,8H,8J,8K,8M,8N,8P,8Q,8R,8S,8 T,8U,8V,8W,8X,8Y,8Z,9B,9C,9D,9E,9G,9H,9J,9K,9M,9N,9 P,9Q,9R,9S,9T,9U,9V,9W,9X,9Y,9Z,A1,A2,A5,A6,A7,AQ,B A,BB,BC,BD,BF,BG,BH,BJ,BK,BM,E2,EH,G1,G2,G4,G5,G6,G 7,G8,G9,HN,K5,MG,MH,MJ,MK,MM,MN,MP,MR,MT,MU, MV,MW,MX,MY,NA,NB,NC,NF,NG,NH,NJ,NK,NP,NQ,NR, NU,NV,NW,NX,NY,N1,N3,N4,N5,N6,N7,N8,N9,PQ,PU,PØ, RL,RQ,RR,RV,RW,RX,RY,RZ,RØ,SØ,S1,S2,S3,S4,S5,S6,S7,S8 ,S9,SA,SB,SC,SD,SF,SG,SH,SJ,SK,SM,SN,SP,SQ,TD,TF,TG,TH ,TJ,TK,TM,TN,TQ,TR,TS,TT,TU,TV,TX,TY,TZ,TØ,T1,T2,T3,T4 ,UA,UU,WØ,W5,W6,W7,W8,W9,XZ,X1,X2,X3,X4,X6,X7,X 8,X9,YA,YB,YC,YD,YE,YF,YG,YH,YJ,YK,YM,YN,YP,YQ,YR,YS,

Segment	Field	Description	D.0 Change Comment
	472-6E		YT,YU,YW,YX,YY,YZ,YØ,Y1,Y2,Y3,Y4,Y5,Y6,Y7,Y8,Y9,ZØ,Z1, Z2,Z3,Z4,Z5,Z6,Z7,Z8,Z9,ZA,ZB,ZC,ZD,ZK,ZM,ZN,ZP,ZQ,ZX, ZY,ZZ,UZ,UØ,U7,VA,VB,VC,VD,VE,VØ,ZD added
Workers Compensation	318-CI	Employer State/Province Code	values YT,NT,NU,QC added, PQ removed
DUR/PPS	439-E4	Reason for Service Code	values DR added, PC,SF,SR,SX,TD,TN and TP removed
DUR/PPS	440-E5	Professional Service Code	values DP,MB,MP,PA,ZZ,AD,AN,AR,AT,CD,CH,CS,DA,DC,DD,DF,D I,DL,DM,DR,DS,ED,ER,EX,HD,IC,ID,LD,LK,LR,MC,MN,MS, MX,NA,NC,ND,NF,NN,NP,NR,NS,OH,PA,PC,PG,PN,PP,PR, PS,RE,RF,SC,SD,SE,SF,SR,SX added
DUR/PPS	441-E6	Result of Service Code	value 4A added
DUR/PPS	475-J9	DUR CO-Agent ID Qualifier	values blank & 13 removed, 27 - 33, 35, 37 added
Pricing	479-H8	Other Amount Claimed Submitted Qualifier	value blank removed and 09 added
Pricing	423-DN	Basis of Cost Determination	value blank removed and 08, 10 - 13 added
Coupon	485-KE	Coupon Type	value blank removed
Compound	488-RE	Compound Ingredient Component Count	values blank, 05, and 13 removed, 15, 28 - 33 added
Compound	490-UE	Compound Ingredient Drug Cost	values 00, 08, 10 - 12 added; blank removed
Clinical	492-WE	Diagnosis Code Qualifier	values 08 and 09 added; blank removed
Clinical	496-H2	Measurement Dimension	values 18 - 34 added
Clinical	497-H3	Measurement Unit	values 19 - 27 added
Response Header	103-A3	Transaction Code	Values D1,S1,S2,S3,F1,F2,F3,F4,F5 added
Response Header	202-B2	Service Provider ID Qualifier	00 removed, 15 and 16 added
Response Status	112-AN	Transaction Response Status	value B added

Segment	Field	Description	D.0 Change Comment
Response Status	511-FB	Reject Code	values 1E,38,H5,RE,TE,and,UE removed,201,2Ø2,2Ø3,2Ø4,2Ø5,2Ø6,2Ø7,2Ø8,2Ø9,21Ø, 211,212,213,214,215,216,217,218,219,22Ø,221,222,223 ,224,225,226,227,228,229,23Ø,231,232,233,234,235,23 6,237,238,239,24Ø,241,242,243,244,245,246,247,248,2 49,251,252,253,254,25
Response Status	549-7F	Help Desk Phone Number Qualifier	value blank removed
Response Claim	552-AP	Preferred Product ID Qualifier	values blank, 5, and 13 removed, 28 - 33, 37 added
Response Pricing	557-AV	Tax Exempt Indicator	value 2 removed, 3 and 4 added
Response Pricing	561-AZ	Percentage Sales Tax Basis Paid	01 removed
Response Pricing	564-J3	Other Amount Paid Qualifier	value blank removed and 09 was added
Response Pricing	522-FM	Basis of Reimbursement Determination	values 10 - 17 added
Response Pricing	346-HH	Amount Exceeding Periodic Benefit Maximum	values blank and 00 removed
Response Pricing	347-HJ	Basis of Calculation-Dispensing Fee	values blank and 00 removed
Response DUR/PPS	439-E4	Reason for Service Code	Values DR and UD added
Response DUR/PPS	528-FS	Clinical Significance Code	value 9 added
Response DUR/PPS	532-FW	Database Indicator	value blanks removed, 6 and 7 added
Response Coordination of Benefits/Other Payments	338-5C	Other Payer Coverage Type	values 04 - 09 added, 98 and 99 removed
Response Coordination of Benefits/Other Payments	339-6C	Other Payer ID Qualifier	values 05 added, 09 removed

NCPDP D.0
BILLING RE-BILL
OVERALL CHANGE REPORT

Items in Red are flagged as Transitions Challenges

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Header	102-A2	Version/Release Number	Version release changed from 5.1 to D.0						
Header	103-A3	Transaction Code	Value = B3 and field 455-EM must be ewual to '1' for Rx Billing.						
Header	202-B2	Service Provider ID Qualifier	00 removed, 15 and 16 added						
Patient Segment	01		Segment requirement changed from optional to situational.						
Patient	331-CX	Patient ID Qualifier	value blank removed, 04 - 11, 1J, EA added. Required when 332-CY is submitted.						
Patient	324-CO	Patient State/Province Code	values YT,NT,NU,QC added, PQ removed						
Patient	307-C7	Place of Service	values 02 and 09 removed; 12 - 16, 20 - 26, 31 - 34, 41, 42, 49 - 57,60 - 62, 65, 71, 72, 81, 99 added. Required if this field could result in different coverage, pricing, or patient financial responsibility.						
Patient	350-HN	Patient E-mail Address	May be submitted for the receiver to relay patient healthcare communications via the Internet when provided by the patient. This field is informational only.						
Patient	384-4X	Patient Residence	Required if this field could result in different coverage,pricing, or patient financial responsibility.						
Insurance	359-2A	Medigap ID	Required, if known, when patient has Medigap coverage.						
Insurance	360-2B	Medicaid Indicator	Required, if known, when patient has Medigap coverage.						
Insurance	361-2D	Provider Accept Assignment Indicator	Required if necessary for state/federal/regulatory agency programs						
Insurance	997-G2	CMS PART D Defined Qualified Facility	Required if specified in trading partner agreement.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Insurance	115-N5	Medicaid ID Number	Required, if known, when patient has Medicaid coverage. Required when used for payer-to-payer coordination of benefits to track the claim without regard to the "Service Provider ID, Prescription Number, & Date of Service".						
Insurance	116-N6	Medicaid Agency Number	Required if the identification to be used in future transactions is different than what was submitted on the request. This field is not used when not submitted as part of Medicaid Subrogation Claim Re-billing.						
Claim	455-EM	Prescription/Service Reference Number Qualifier	value blank removed						
Claim	**402-D2**	**Prescription/Service Reference Number**	**field lengthened from 7 to 12 bytes**						
Claim	436-E1	Product/Service ID Qualifier	value blank, 05, and 13 removed, values 15, 27 - 34 added. If billing for a multi-ingredient prescription, Product/Service ID Qualifier (436-E1) is zero ("00").						
Claim	**456-EN**	**Associated Prescription/Service Date Qualifier**	**field lengthened from 7 to 12 bytes. Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription.**						
Claim	**458-SE**	**Procedure Modifier Code Count**	**maximum occurrences increased to 10 removed the recommend number of occurrences with D.0, field lengthened from 1 to 2 bytes. Required if Procedure Modifier Code (459-ER) is used.**						
Claim	459-ER	Procedure Modifier Code	Please check the referenced CMS web site referenced in the 5.1 & D.0 code values columns for the latest list of codes. Required to define a further level of specificity if the Product/Service ID (4Ø7-D7) indicated a Procedure Code was submitted. Required if this field could result in different coverage, pricing, or patient financial responsibility. Occurs the number of times identified in Procedure Modifier Code Count (458-SE).						
Claim	419-DJ	Prescription Origin Code	value 5 added						
Claim	354-NX	Submission Clarification Code Count	new - maximum of 3 occurrences. Required if Submission Clarification Code (42Ø-DK) is used.						
Claim	420-DK	Submission Clarification Code	values 00, 10 through 19 added						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Claim	308-C8	Other Coverage Code	Values: Modify definition: 8 = Claim is billing for patient financial responsibility only; 3=Other Coverage Billed – claim not covered; Ø= Not specified by patient. Values 05, 06, 07 removed						
Claim	429-DT	Special Packaging Indicator	values 4 and 5 added						
Claim	453-EJ	Original Prescribed Product/Service ID Qualifier	values blank, 05, and 13 removed and 15, 28 - 33 added						
Claim	461-EU	Prior Authorization Type Code	value 09 added. Also note that the definition for value 04 changed to, 'Exemption from Copay and/or Coinsurance'.						
Claim	343-HD	Dispensing Status	value blank removed. Required for the partial fill or the completion fill of a prescription.						
Claim	357-NV	Delay Reason code	Required when needed to specify the reason that submission of the transaction has been delayed.						
Claim	391-MT	Patient Assignment Indicator (Direct Member Reimbursement Indicator)	Required if needed per trading partner agreement.						
Claim	995-E2	Route of Admission	Required if needed per trading partner agreement.						
Claim	996-G1	Compound Type	Required if needed per trading partner agreement.						
Claim	114-N4	Medicaid Subrogation internal Control Number/Transaction Control Number (ICN/TCN)	Required to report back on the response the claim number assigned by the Medicaid Agency. This field is only submitted as part of a Mediciad Subrogation Claim Re-billing else not used in a B3 transaction.						
Claim	147-U7	Pharmacy Service Type	Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer see Appendix 28.1.9 of the version D.0 Telecommunication Standard Implementation guide for details.						
Pharmacy Provider Segment	02		Segment requirement changed from optional to situational.						
Pharmacy Provide	465-EY	Provider ID Qualifier	value blank removed						
Prescriber Segment	03		Segment requirement changed from optional to situational.						
Prescriber	466-EZ	Prescriber ID Qualifier	value blank and 07 removed, 15 added						
Prescriber	467-1E	Prescriber Location Code	Removed in prior version						
Prescriber	468-2E	Prescriber Phone Number	value 00 and 07 removed, 15 added						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Prescriber	469-H5	Primary Provider Location Code	Removed in prior version						
Prescriber	364-2J	Primary Care Provider Last Name	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.						
Prescriber	365-2K	Primary Care Provider First Name	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.						
Prescriber	366-2M	Prescriber Street Address	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.						
Prescriber	367-2N	Prescriber City Address	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.						
Prescriber	368-2P	Prescriber State/Province Code	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.						
COB/ other payments	05		Segment requirement changed from optional to situational.						
COB/other payments	337-4C	Coordination of Benefits/Other Payments Count	maximum 9 occurrences recommended restriction of 3 or less was removed in D.0						
COB/other payme	338-5C	Other Payer Coverage Type	values 98 and 99 removed, 04 - 09 added						
COB/other payme	339-6C	Other Payer ID Qualifier	value 05 added, blank and 09 removed						
COB/other payments	993-A7	Internal Control Number	Required when used for payer-to-payer coordination of benefits to track the claim without regard to the "Service provider id, Prescription Number, & Date of Service".						
COB/other payments	341-HB	Other Payer Amount Paid Count	maximum 9 occurrences and the recommended limitation verbiage was removed in D.0						
COB/other payme	342-HC	Other Payer Amount Paid Qualifier	values blank, 08, 98, 99 removed						
COB/other payments	471-5E	Other Payer Reject Count	maximum 5 occurrences with D.0. Version 5.1 allowed a maximum of 20 with a recommended restriction of 5 or less.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
COB/other payments	472-6E	Other Payer Reject Code	values 1E,38,H5,RE,TE,and,UE removed, 201,2Ø2,2Ø3,2Ø4,2Ø5,2Ø6,2Ø7,2Ø8,2Ø9,21Ø,211,212, 213,214,215,216,217,218,219,22Ø,221,222,223,224,225 ,226,227,228,229,23Ø,231,232,233,234,235,236,237,23 8,239,24Ø,241,242,243,244,245,246,247,248,249,251,2 52,253,254,255,256,257,258,259,26Ø,261,262,263,264, 265,266,267,268,269,27Ø,271,272,273,274,275,276,277 ,278,279,28Ø,281,282,283,284,285,286,287,288,289,29 Ø,291,292,293,294,295,296,297,298,299,3ØØ,3Ø1,3Ø2, 3Ø3,3Ø4,3Ø5,3Ø6,3Ø7,3Ø8,3Ø9,31Ø,311,312,313,314,3 15,316,317,318,319,32Ø,321,322,323,324,325,326,327, 328,329,33Ø,331,332,333,334,335,336,337,338,339,34Ø ,341,342,343,344,345,346,347,348,349,35Ø,351,352,35 3,354,355,356,357,358,359,36Ø,361,363,364,365,366,3 67,368,369,37Ø,371,372,373,374,375,376,377,378,379, 38Ø,381,382,383,384,385,386,387,388,389,39Ø,391,392 ,393,394,395,396,397,398,399,4ØØ,4Ø1,4Ø2,4Ø3,4Ø4,4 Ø5,4Ø6,4Ø7,4Ø9,41Ø,411,412,413,414,415,416,417,418 ,419,42Ø,421,422,423,424,425,426,427,428,429,43Ø,43 1,432,433,434,435,436,437,438,439,44Ø,441,442,443,4 45,446,447,448,449,45Ø,451,452,453,454,455,456,457, 458,459,46Ø,461,462,463,1R,1S,1T,1U,1V,1W,1X,1Y,1Z, 2A,2B,2D,2G,2H,2J,2K,2M,2N,2P,2Q,2R,2S,2T,2U,2V,2W, 2X,2Z,2G,2H,2J,2K,2M,2N,2P,2Q,2R,2S,2T,2U,2V,2W,2X, 2Z,3Q,3U,3V,4B,4D,4G,4J,4K,4M,4N,4P,4Q,4R,4S,4T,4W, 4X,4Y,4Z,5J,6D,6G,6H,6J,6N,6P,6Q,6R,6S,6T,6U,6V,6W,6 X,6Z,7B,7D,7F,7G,7J,7K,7M,7N,7P,7Q,7R,7S,7T,7U,7V,7 W,7X,7Y,7Z,8A,8B,8D,8G,8H,8J,8K,8M,8N,8P,8Q,8R,8S,8 T,8U,8V,8W,8X,8Y,8Z,9B,9C,9D,9E,9G,9H,9J,9K,9M,9N,9 P,9Q,9R,9S,9T,9U,9V,9W,9X,9Y,9Z,A1,A2,A5,A6,A7,AQ,B A,BB,BC,BD,BF,BG,BH,BJ,BK,BM,E2,EH,G1,G2,G4,G5,G6, G7,G8,G9,HN,K5,MG,MH,MJ,MK,MM,MN,MP,MR,MT,M U,MV,MW,MX,MY,NA,NB,NC,NF,NG,NH,NJ,NK,NP,NQ,N R,NU,NV,NW,NX,NY,N1,N3,N4,N5,N6,N7,N8,N9,PQ,PU,P Ø,RL,RQ,RR,RV,RW,RX,RY,RZ,RØ,SØ,S1,S2,S3,S4,S5,S6,S7 ,S8,S9,SA,SB,SC,SD,SF,SG,SH,SJ,SK,SM,SN,SP,SQ,TD,TF,TG ,TH,TJ,TK,TM,TN,TQ,TR,TS,TT,TU,TV,TX,TY,TZ,TØ,T1,T2,T 3,T4,UA,UU,WØ,W5,W6,W7,W8,W9,XZ,X1,X2,X3,X4,X6, X7,X8,X9,YA,YB,YC,YD,YE,YF,YG,YH,YJ,YK,YM,YN,YP,YQ,Y R,YS,YT,YU,YW,YX,YY,YZ,YØ,Y1,Y2,Y3,Y4,Y5,Y6,Y7,Y8,Y9,Z Ø,Z1,Z2,Z3,Z4,Z5,Z6,Z7,Z8,Z9,ZA,ZB,ZC,ZD,ZK,ZM,ZN,ZP,Z Q,ZX,ZY,ZZ,UZ,UØ,U7,VA,VB,VC,VD,VE,VØ,ZD added						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
COB/other payments	353-NR	Other Payer-Patient Responsibility Amount Count	New - maximum 25 occurrences. Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. Note the occurrences are dependent upon the number of component parts returned from a previous payer.						
COB/other payments	351-NP	Other Payer-Patient Responsibility Amount Qualifier	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. Values 02,08, Ø9, 1Ø, 11, 12, and 13						
COB/other payments	352-NQ	Other Payer-Patient Responsibility Amount	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.						
COB/other payments	392-MU	Benefit Stage Count	New - maximum count 4. Required if Benefit Stage Amount (394-MW) is used.						
COB/other payments	393-MV	Benefit Stage Qualifier	Required if Benefit Stage Amount (394-MW) is used. Must only have one value per iteration - value must not be repeated.						
COB/other payments	394-MW	Benefit Stage Amount	Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefitstage specific financial amounts. Required if necessary for state/federal/regulatory agency programs.						
Workers Compens	318-CI	Employer State/Province Code	values YT,NT,NU,QC added, PQ removed						
Workers Compensation	117-TR	Billing Entity Type Indicator	This field is required for Rebill of claims or services and for Prior Authorization Request & Billing for claims and services.						
Workers Compens	118-TS	Pay-To Qualifier	Required if Pay To ID (119-TT) is used.						
Workers Compensation	119-TT	Pay-To ID	Required if transaction is submitted by a provider or agent, ut paid to another party.						
Workers Compensation	120-TU	Pay-To Name	Required if transaction is submitted by a provider or agent, ut paid to another party.						
Workers Compensation	121-TV	Pay-To Street Address	Required if transaction is submitted by a provider or agent, but paid to another party.						
Workers Compensation	122-TW	Pay-To City Address	Required if transaction is submitted by a provider or agent, but paid to another party.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Workers Compensation	123-TX	Pay-To State/Province Code	Required if transaction is submitted by a provider or agent, but paid to another party.						
Workers Compensation	124-TY	Pay-To Zip/Postal Code	Required if transaction is submitted by a provider or agent, but paid to another party.						
Workers Compensation	125-TZ	Generic Equivalent Product ID Qualifier	Required if Generic Equivalent Product ID (126-UA) is used.						
Workers Compensation	126-UA	Generic Equivalent Product ID	Required if necessary for state/federal/regulatory agency programs.						
DUR/PPS Segment	08		Segment requirement changed from optional to situational.						
DUR/PPS	473-7E	DUR/PPS Code Counter	maximum 9 occurrences supported and recommended verbiage has been removed in D.0						
DUR/PPS	439-E4	Reason for Service Code	values DR added, PC,SF,SR,SX,TD,TN and TP removed						
DUR/PPS	440-E5	Professional Service Code	values DP,MB,MP,PA,ZZ,AD,AN,AR,AT,CD,CH,CS,DA,DC,DD,DF, DI,DL,DM,DR,DS,ED,ER,EX,HD,IC,ID,LD,LK,LR,MC,MN,MS, MX,NA,NC,ND,NF,NN,NP,NR,NS,OH,PA,PC,PG,PN,PP,PR, PS,RE,RF,SC,SD,SE,SF,SR,SX added						
DUR/PPS	441-E6	Result of Service Code	value 4A added						
DUR/PPS	475-J9	DUR CO-Agent ID Qualifier	values blank & 13 removed, 27 - 33, 35, 37 added						
Pricing	478-H7	Other Amount Claimed Submitted Count	maximum 3 occurrences with D.0 version 5.1 had a maximum of 9 recommended 3 occurrences or less.						
Pricing	479-H8	Other Amount Claimed Submitted Qualifier	value blank removed and 09 added						
Pricing	423-DN	Basis of Cost Determination	value blank removed and 08, 10 - 13 added						
Pricing	113-N3	Medicaid Paid Amount	Required if affects pricing in Medicaid Subrogation (contains the amount paid to the pharmacy). This field should only be submitted when the re-bill is part of a Medicaid Subrogation claim else this field is not used as part of a B3 claim Re-billing transaction.						
Coupon Segment	09		Segment requirement changed from optional to situational.						
Coupon	485-KE	Coupon Type	value blank removed						
Compound Segment	10		Segment requirement changed from optional to situational.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Compound	452-EH	Compound route of Administration	Removed in prior version						
Compound	447-EC	Compound Route of Administration	maximum 25 ingredients in D.0 version 5.1 had maximum at 99 with 25 as recommended.						
Compound	488-RE	Compound Ingredient Component Count	values blank, 05, and 13 removed, 15, 28 - 33 added						
Compound	490-UE	Compound Ingredient Drug Cost	values 00, 08, 10 - 12 added; blank removed						
Compound	362-2G	Compound Ingredient Basis of Cost Determination	Required when Compound Ingredient Modifier Code (363-2H) is sent. Maximum count of 10.						
Compound	363-2H	Compound Ingredient Modifier Code Count	Required if necessary for state/federal/regulatory agency programs.						
Clinical Segment	13		Segment requirement changed from optional to situational.						
Clinical	491-VE	Diagnosis Code Count	maximum 5 occurrences with D.0 version 5.1 had maximum at 9 with 5 as recommended.						
Clinical	492-WE	Diagnosis Code Qualifier	values 08 and 09 added; blank removed						
Clinical	493-XE	Clinical Information Counter	maximum 5 occurrences in D.0 version 5.1 allowed a maximum of 9 with 5 or less recommended.						
Clinical	496-H2	Measurement Dimension	values 18 - 34 added						
Clinical	497-H3	Measurement Unit	values 19 - 27 added						
Additional Documentation segment	14		The Additional Documentation Segment is situational for Claim Rebill request. It is used to provide additional information on Medicare forms.						
Additional Documentation	369-2Q	Additional Documentation Type ID	Unique identifier for the data being submitted. Values 001-015						
Additional Documentation	374-2V	Request Period Begin Date	Required if necessary for state/federal/regulatory agency programs.						
Additional Documentation	375-2W	Request Period Recert/Revised Date	Required if necessary for state/federal/regulatory agency programs. Required if the Request Status (373-2U) = “2” (Revision) or “3” (Recertification).						
Additional Documentation	373-2U	Request Status	Required if necessary for state/federal/regulatory agency programs.						
Additional Docum	371-2S	Length of Need Qualifier	Required if Length of Need (370-2R) is used.						
Additional Documentation	370-2R	Length of Need	Required if necessary for state/federal/regulatory agency programs.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Additional Documentation	372-2T	Prescriber/Supplier Date Signed	Required if necessary for state/federal/regulatory agency programs.						
Additional Documentation	376-2X	Supporting Documentation	Required if necessary for state/federal/regulatory agency programs (using Section C of Medicare's CMN forms).						
Additional Documentation	377-2Z	Question Number/Letter Count	New - maximum 50 occurrences. Required if needed to provide response to narratives.						
Additional Documentation	378-4B	Question Number/Letter	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form. Required if Question Number/Letter Count (377-2Z) is greater than 0.						
Additional Documentation	379-4D	Question Percent Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Additional Documentation	380-4G	Question Date Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Additional Documentation	381-4H	Question Dollar Amount Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Additional Documentation	382-4J	Question Numeric Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Additional Documentation	383-4K	Question Alphabetic Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Facility Segment	15		The Facility Segment is situational for Claim Rebill request. It is used when these fields could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.						
Facility	385-3Q	Facility Name	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Facility	386-3U	Facility Street Address	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.						
Facility	388-5J	Facility City Address	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.						
Facility	387-3V	Facility State/Province Code	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.						
Facility	389-6D	Facility Zip/Postal Code	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.						
Narrative	390-BM	Narrative Message	Required if necessary only to support exception handling of pharmacy claims for Medicare Part B claim billing.						
Response Header	103-A3	Transaction Code	Values D1,S1,S2,S3,F1,F2,F3,F4,F5 added						
Response Header	202-B2	Service Provider ID Qualifier	00 removed, 15 and 16 added						
Response Insurance	115-N5	Medicaid ID Number	Required, if known, when patient has Medicaid coverage. Required when used for payer-to-payer coordination of benefits to track the claim without regard to the “Service Provider ID, Prescription Number, & Date of Service”. This field should only be sent when performing Medicaid Subrogation Re-bill otherwise this field is not used on a standard claim re-bill transaction.						
Response Insurance	116-N6	Medicaid Agency Number	Required to identify the Medicaid agency. This field should only be sent when performing Medicaid Subrogation Re-bill otherwise this field is not used on a standard claim re-bill transaction.						
Response Patient Segment	29		New Segment added with D.0. This segment is used for Medicare Part D Eligibility transactions to provide patient name and date of birth in order to provide additional patient information. This information could assist in the verification that the eligibility information returned is indeed the patient for which the eligibility request was intended.						
Response Status	112-AN	Transaction Response Status	value B added						
Response Status	510-FA	Reject Count	maximum 5 occurrences in D.0 version 5.1 allowed a maximum of 99 with 5 or less recommended.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Status	511-FB	Reject Code	values 1E,38,H5,RE,TE,and,UE removed,201,2Ø2,2Ø3,2Ø4,2Ø5,2Ø6,2Ø7,2Ø8,2Ø9,21Ø, 211,212,213,214,215,216,217,218,219,22Ø,221,222,223 ,224,225,226,227,228,229,23Ø,231,232,233,234,235,23 6,237,238,239,24Ø,241,242,243,244,245,246,247,248,2 49,251,252,253,254,25						
Response Status	547-5F	Approved Message Code Count	maximum 5 occurrences in D.0 version 5.1 had a maximum of 9 with 5 or less recommended.						
Response Status	548-6F	Approved Message Code	Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. This field repeats the number of times indicated in field 547-5f.						
Response Status	130-UF	Additional Message Information Count	Required if Additional Message Information (526-FQ) is used. Used to qualify the number of occurrences of the Additional Message Information (526-FQ) that is included in the Response Status Segment. Maximum number of occurences is 25.						
Response Status	132-UH	Additional Message Information Qualifier	Required if Additional Message Information (526-FQ) is used.						
Response Status	**526-FQ**	**Additional Message Information**	**field length reduced from 200 to 40 bytes and added repeat functionality**						
Response Status	131-UG	Additional Message Information Continuity	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.						
Response Status	549-7F	Help Desk Phone Number Qualifier	value blank removed						
Response Status	993-A7	Internal Control Number	Required when used for payer-to-payer coordination of benefits to track the claim without regard to the “Service provider id, Prescription Number, & Date of Service”.						
Response Claim	**402-D2**	**Prescription/Service Reference Number**	**field lengthened from 7 to 12 bytes**						
Response Claim	551-9F	Preferred Product Count	maximum 6 occurrences in D.0 version 5.1 allowed maximum of 9 with 6 or less recommended.						
Response Claim	552-AP	Preferred Product ID Qualifier	values blank, 5, and 13 removed, 28 - 33, 37 added						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Claim	114-N4	Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)	Required to report back on the response the claim number assigned by the Medicaid Agency. This field should only be sent when performing Medicaid Subrogation Re-bill otherwise this field is not used on a standard claim re-bill transaction.						
Response Pricing	557-AV	Tax Exempt Indicator	value 2 removed, 3 and 4 added						
Response Pricing	561-AZ	Percentage Sales Tax Basis Paid	01 removed						
Response Pricing	563-J2	Other Amount Paid Count	maximum 3 occurrences in D.0 version 5.1 allowed maximum of 9 with 3 or less recommended.						
Response Pricing	564-J3	Other Amount Paid Qualifier	value blank removed and 09 was added						
Response Pricing	522-FM	Basis of Reimbursement Determination	values 10 - 17 added						
Response Pricing	519-FJ	Amount Attributed To Product Selection	Removed in prior version						
Response Pricing	346-HH	Amount Exceeding Periodic Benefit Maximum	values blank and 00 removed						
Response Pricing	347-HJ	Basis of Calculation-Dispensing Fee	values blank and 00 removed						
Response Pricing	571-NZ	Basis of Calculation-Percentage Sales Tax	Required if the customer is responsible for 100% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay.						
Response Pricing	575-EQ	Amount Attributed to Processor Fee	Used when necessary to identify the Patient's portion of the Sales Tax. Provided for informational purposes only.						
Response Pricing	574-2Y	Patient Sales Tax Amount	Used when necessary to identify the Plan's portion of the Sales Tax. Provided for informational purposes only.						
Response Pricing	572-4U	Plan Sales Tax Amount	Required if Patient Pay Amount (5Ø5-F5) includes coinsurance as patient financial responsibility.						
Response Pricing	573-4V	Amount of Coinsurance	Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill).						
Response Pricing	392-MU	Basis of Calculation-Coinsurance	New - maximum 3 occurrences. Required if Benefit Stage Amount (394-MW) is used.						
Response Pricing	393-MV	Benefit Stage Count	Required if Benefit Stage Amount (394-MW) is used. Must only have one value per iteration - value must not be repeated.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Pricing	394-MW	Benefit Stage Qualifier	Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs.						
Response Pricing	577-G3	Benefit Stage Amount	This information should be provided when a patient selected the brand drug and a generic form of the drug was available. It will contain an estimate of the difference between the cost of the brand drug and the generic drug, when the brand drug is more expensive than the generic. It is information that the provider should provide to the patient.						
Response Pricing	128-UC	Estimated Generic Savings	This dollar amount will be provided, if known, to the receiver when the transaction had spending account dollars reported as part of the patient pay amount. This field is informational only. It is reported back to the provider and the patient the amount remaining on the spending account after the current claim updated the spending account.						
Response Pricing	129-UD	Spending Account Amount Remaining	Required when the patient meets the plan-funded assistance criteria, to reduce Patient Pay Amount (5Ø5-F5). The resulting Patient Pay Amount (5Ø5-F5) must be greater than or equal to zero. This field is always a negative amount or zero.						
Response Pricing	133-UJ	Health Plan-Funded Assistance Amount	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another.						
Response Pricing	134-UK	Amount Attributed to Provider Network Selection	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand drug.						
Response Pricing	135-UM	Amount Attributed to Product Selection/Brand Drug	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a nonpreferred formulary product.						
Response Pricing	136-UN	Amount Attributed to Product Selection/Non-Preferred Formulary Selection	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand non-preferred formulary product.						
Response Pricing	137-UP	Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection	Required when the patient's financial responsibility is due to the coverage gap.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Pricing	148-U8	Amount Contributed to Coverage Gap	Required when Basis of Reimbursement Determination (522-FM) is “14” (Patient Responsibility Amount) or “15” (Patient Pay Amount) unless prohibited by state/federal/regulatory agency. This field is informational only.						
Response Pricing	149-U9	Ingredient Cost Contracted/Reimbursable Amount	Required when Basis of Reimbursement Determination (522-FM) is “14” (Patient Responsibility Amount) or “15”(Patient Pay Amount) unless prohibited by state/federal/regulatory agency. This field is informational only.						
Response DUR/PPS	567-J6	DUR/PPS Response Code Qualifier	maximum 9 occurrences removed the recommended verbiage with D.0						
Response DUR/PP	439-E4	Reason for Service Code	Values DR and UD added						
Response DUR/PP	528-FS	Clinical Significance Code	value 9 added						
Response DUR/PP	532-FW	Database Indicator	value blanks removed, 6 and 7 added						
Response COB/ot	28		New segment added with D.0						
Response Coordination of	355-NT	Other Payer ID Count	New - maximum 3 occurrences. Count of other payers with payment responsibility.						
Response Coordin	338-5C	Other Payer Coverage Type	values 04 - 09 added, 98 and 99 removed						
Response Coordin	339-6C	Other Payer ID Qualifier	values 05 added, 09 removed						
Response Coordination of	991-MH	Other Payer Processor Control Number	Required if other insurance information is available for coordination of benefits.						
Response Coordination of	356-NU	Other Payer Cardholder ID	Required if other insurance information is available for coordination of benefits.						
Response Coordination of	992-MJ	Other Payer Group Id	Required if other insurance information is available for coordination of benefits.						
Response Coordination of Benefits/Other	142-UV	Other Payer Person Code	Required if needed to uniquely identify the family members within the CardholderID, as assigned by the other payer.						
Response Coordination of	127-UB	Other Payer Help Desk Phone Number	Required if needed to provide a support telephone number f the other payer to the receiver.						
Response Coordination of Benefits/Other	143-UW	Other Payer Patient Relationship Code	Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer.						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Coordination of	144-UX	Other Payer Benefit Effective Date	Required when other coverage is known which is after the Date of Service submitted.						
Response Coordination of	145-UY	Other Payer Benefit Termination Date	Required when other coverage is known which is after the Date of Service submitted.						

NCPDP D.0
BILLING RE-BILL
NEW CONTENT REPORT

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Patient	350-HN	Patient E-mail Address	May be submitted for the receiver to relay patient healthcare communications via the Internet when provided by the patient. This field is informational only.
Patient	384-4X	Patient Residence	Required if this field could result in different coverage,pricing, or patient financial responsibility.
Insurance	359-2A	Medigap ID	Required, if known, when patient has Medigap coverage.
Insurance	360-2B	Medicaid Indicator	Required, if known, when patient has Medigap coverage.
Insurance	361-2D	Provider Accept Assignment Indicator	Required if necessary for state/federal/regulatory agency programs
Insurance	997-G2	CMS PART D Defined Qualified Facility	Required if specified in trading partner agreement.
Insurance	115-N5	Medicaid ID Number	Required, if known, when patient has Medicaid coverage. Required when used for payer-to-payer coordination of benefits to track the claim without regard to the “Service Provider ID, Prescription Number, & Date of Service”.
Insurance	116-N6	Medicaid Agency Number	Required if the identification to be used in future transactions is different than what was submitted on the request. This field is not used when not submitted as part of Medicaid Subrogation Claim Re-billing.
Claim	354-NX	Submission Clarification Code Count	new - maximum of 3 occurrences. Required if Submission Clarification Code (42Ø-DK) is used.
Claim	357-NV	Delay Reason code	Required when needed to specify the reason that submission of the transaction has been delayed.
Claim	391-MT	Patient Assignment Indicator (Direct Member Reimbursement Indicator)	Required if needed per trading partner agreement.

Segment	Field	Description	D.0 Change Comment
Claim	995-E2	Route of Admission	Required if needed per trading partner agreement.
Claim	996-G1	Compound Type	Required if needed per trading partner agreement.
Claim	114-N4	Medicaid Subrogation internal Control Number/Transaction Control Number (ICN/TCN)	Required to report back on the response the claim number assigned by the Medicaid Agency. This field is only submitted as part of a Mediciad Subrogation Claim Re-billing else not used in a B3 transaction.
Claim	147-U7	Pharmacy Service Type	Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer see Appendix 28.1.9 of the version D.0 Telecommunication Standard Implementation guide for details.
Prescriber	364-2J	Primary Care Provider Last Name	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.
Prescriber	365-2K	Primary Care Provider First Name	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.
Prescriber	366-2M	Prescriber Street Address	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.
Prescriber	367-2N	Prescriber City Address	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.
Prescriber	368-2P	Prescriber State/Province Code	Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.
COB/other payments	993-A7	Internal Control Number	Required when used for payer-to-payer coordination of benefits to track the claim without regard to the “Service provider id, Prescription Number, & Date of Service”.

Segment	Field	Description	D.0 Change Comment
COB/other payments	353-NR	Other Payer-Patient Responsibility Amount Count	New - maximum 25 occurrences. Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. Note the occurrences are dependent upon the number of component parts returned from a previous payer.
COB/other payments	351-NP	Other Payer-Patient Responsibility Amount Qualifier	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. Values 02,08, Ø9, 1Ø, 11, 12, and 13
COB/other payments	352-NQ	Other Payer-Patient Responsibility Amount	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.
COB/other payments	392-MU	Benefit Stage Count	New - maximum count 4. Required if Benefit Stage Amount (394-MW) is used.
COB/other payments	393-MV	Benefit Stage Qualifier	Required if Benefit Stage Amount (394-MW) is used. Must only have one value per iteration - value must not be repeated.
COB/other payments	394-MW	Benefit Stage Amount	Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefitstage specific financial amounts. Required if necessary for state/federal/regulatory agency programs.
Workers Compensation	117-TR	Billing Entity Type Indicator	This field is required for Rebill of claims or services and for Prior Authorization Request & Billing for claims and services.
Workers Compensation	118-TS	Pay-To Qualifier	Required if Pay To ID (119-TT) is used.
Workers Compensation	119-TT	Pay-To ID	Required if transaction is submitted by a provider or agent, ut paid to another party.
Workers Compensation	120-TU	Pay-To Name	Required if transaction is submitted by a provider or agent, ut paid to another party.

Segment	Field	Description	D.0 Change Comment
Workers Compensation	121-TV	Pay-To Street Address	Required if transaction is submitted by a provider or agent, but paid to another party.
Workers Compensation	122-TW	Pay-To City Address	Required if transaction is submitted by a provider or agent, but paid to another party.
Workers Compensation	123-TX	Pay-To State/Province Code	Required if transaction is submitted by a provider or agent, but paid to another party.
Workers Compensation	124-TY	Pay-To Zip/Postal Code	Required if transaction is submitted by a provider or agent, but paid to another party.
Workers Compensation	125-TZ	Generic Equivalent Product ID Qualifier	Required if Generic Equivalent Product ID (126-UA) is used.
Workers Compensation	126-UA	Generic Equivalent Product ID	Required if necessary for state/federal/regulatory agency programs.
Pricing	113-N3	Medicaid Paid Amount	Required if affects pricing in Medicaid Subrogation (contains the amount paid to the pharmacy). This field should only be submitted when the re-bill is part of a Medicaid Subrogation claim else this field is not used as part of a B3 claim Re-billing transaction.
Compound	362-2G	Compound Ingredient Basis of Cost Determination	Required when Compound Ingredient Modifier Code (363-2H) is sent. Maximum count of 10.
Compound	363-2H	Compound Ingredient Modifier Code Count	Required if necessary for state/federal/regulatory agency programs.
Additional Documentation segment	14		The Additional Documentation Segment is situational for Claim Rebill request. It is used to provide additional information on Medicare forms.
Additional Documentation	369-2Q	Additional Documentation Type ID	Unique identifier for the data being submitted. Values 001-015
Additional Documentation	374-2V	Request Period Begin Date	Required if necessary for state/federal/regulatory agency programs.
Additional Documentation	375-2W	Request Period Recert/Revised Date	Required if necessary for state/federal/regulatory agency programs. Required if the Request Status (373-2U) = “2” (Revision) or “3” (Recertification).

Segment	Field	Description	D.0 Change Comment
Additional Documentation	373-2U	Request Status	Required if necessary for state/federal/regulatory agency programs.
Additional Documentation	371-2S	Length of Need Qualifier	Required if Length of Need (370-2R) is used.
Additional Documentation	370-2R	Length of Need	Required if necessary for state/federal/regulatory agency programs.
Additional Documentation	372-2T	Prescriber/Supplier Date Signed	Required if necessary for state/federal/regulatory agency programs.
Additional Documentation	376-2X	Supporting Documentation	Required if necessary for state/federal/regulatory agency programs (using Section C of Medicare's CMN forms).
Additional Documentation	377-2Z	Question Number/Letter Count	New - maximum 50 occurrences. Required if needed to provide response to narratives.
Additional Documentation	378-4B	Question Number/Letter	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form. Required if Question Number/Letter Count (377-2Z) is greater than 0.
Additional Documentation	379-4D	Question Percent Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)
Additional Documentation	380-4G	Question Date Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)
Additional Documentation	381-4H	Question Dollar Amount Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)
Additional Documentation	382-4J	Question Numeric Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)

Segment	Field	Description	D.0 Change Comment
Additional Documentation	383-4K	Question Alphabetic Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)
Facility Segment	15		The Facility Segment is situational for Claim Rebill request. It is used when these fields could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.
Facility	385-3Q	Facility Name	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.
Facility	386-3U	Facility Street Address	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.
Facility	388-5J	Facility City Address	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.
Facility	387-3V	Facility State/Province Code	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.
Facility	389-6D	Facility Zip/Postal Code	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.
Narrative	390-BM	Narrative Message	Required if necessary only to support exception handling of pharmacy claims for Medicare Part B claim billing.
Response Insurance	115-N5	Medicaid ID Number	Required, if known, when patient has Medicaid coverage. Required when used for payer-to-payer coordination of benefits to track the claim without regard to the “Service Provider ID, Prescription Number, & Date of Service”. This field should only be sent when performing Medicaid Subrogation Re-bill otherwise this field is not used on a standard claim re-bill transaction.

Segment	Field	Description	D.0 Change Comment
Response Insurance	116-N6	Medicaid Agency Number	Required to identify the Medicaid agency. This field should only be sent when performing Medicaid Subrogation Re-bill otherwise this field is not used on a standard claim re-bill transaction.
Response Patient Segment	29		New Segment added with D.0. This segment is used for Medicare Part D Eligibility transactions to provide patient name and date of birth in order to provide additional patient information. This information could assist in the verification that the eligibility information returned is indeed the patient for which the eligibility request was intended.
Response Status	548-6F	Approved Message Code	Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. This field repeats the number of times indicated in field 547-5f.
Response Status	130-UF	Additional Message Information Count	Required if Additional Message Information (526-FQ) is used. Used to qualify the number of occurrences of the Additional Message Information (526-FQ) that is included in the Response Status Segment. Maximum number of occurences is 25.
Response Status	132-UH	Additional Message Information Qualifier	Required if Additional Message Information (526-FQ) is used.
Response Status	131-UG	Additional Message Information Continuity	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.
Response Status	993-A7	Internal Control Number	Required when used for payer-to-payer coordination of benefits to track the claim without regard to the “Service provider id, Prescription Number, & Date of Service”.

Segment	Field	Description	D.0 Change Comment
Response Claim	114-N4	Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)	Required to report back on the response the claim number assigned by the Medicaid Agency. This field should only be sent when performing Medicaid Subrogation Re-bill otherwise this field is not used on a standard claim re-bill transaction.
Response Pricing	571-NZ	Basis of Calculation-Percentage Sales Tax	Required if the customer is responsible for 100% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay.
Response Pricing	575-EQ	Amount Attributed to Processor Fee	Used when necessary to identify the Patient's portion of the Sales Tax. Provided for informational purposes only.
Response Pricing	574-2Y	Patient Sales Tax Amount	Used when necessary to identify the Plan's portion of the Sales Tax. Provided for informational purposes only.
Response Pricing	572-4U	Plan Sales Tax Amount	Required if Patient Pay Amount (5Ø5-F5) includes coinsurance as patient financial responsibility.
Response Pricing	573-4V	Amount of Coinsurance	Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill).
Response Pricing	392-MU	Basis of Calculation-Coinsurance	New - maximum 3 occurrences. Required if Benefit Stage Amount (394-MW) is used.
Response Pricing	393-MV	Benefit Stage Count	Required if Benefit Stage Amount (394-MW) is used. Must only have one value per iteration - value must not be repeated.
Response Pricing	394-MW	Benefit Stage Qualifier	Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs.

Segment	Field	Description	D.0 Change Comment
Response Pricing	577-G3	Benefit Stage Amount	This information should be provided when a patient selected the brand drug and a generic form of the drug was available. It will contain an estimate of the difference between the cost of the brand drug and the generic drug, when the brand drug is more expensive than the generic. It is information that the provider should provide to the patient.
Response Pricing	128-UC	Estimated Generic Savings	This dollar amount will be provided, if known, to the receiver when the transaction had spending account dollars reported as part of the patient pay amount. This field is informational only. It is reported back to the provider and the patient the amount remaining on the spending account after the current claim updated the spending account.
Response Pricing	129-UD	Spending Account Amount Remaining	Required when the patient meets the plan-funded assistance criteria, to reduce Patient Pay Amount (5Ø5-F5). The resulting Patient Pay Amount (5Ø5-F5) must be greater than or equal to zero. This field is always a negative amount or zero.
Response Pricing	133-UJ	Health Plan-Funded Assistance Amount	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another.
Response Pricing	134-UK	Amount Attributed to Provider Network Selection	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand drug.
Response Pricing	135-UM	Amount Attributed to Product Selection/Brand Drug	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a nonpreferred formulary product.
Response Pricing	136-UN	Amount Attributed to Product Selection/Non-Preferred Formulary Selection	Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand non-preferred formulary product.
Response Pricing	137-UP	Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection	Required when the patient's financial responsibility is due to the coverage gap.

Segment	Field	Description	D.0 Change Comment
Response Pricing	148-U8	Amount Contributed to Coverage Gap	Required when Basis of Reimbursement Determination (522-FM) is “14” (Patient Responsibility Amount) or “15” (Patient Pay Amount) unless prohibited by state/federal/regulatory agency. This field is informational only.
Response Pricing	149-U9	Ingredient Cost Contracted/Reimbursable Amount	Required when Basis of Reimbursement Determination (522-FM) is “14” (Patient Responsibility Amount) or “15”(Patient Pay Amount) unless prohibited by state/federal/regulatory agency. This field is informational only.
Response COB/other payments Segment	28		New segment added with D.0
Response Coordination of Benefits/Other Payments	355-NT	Other Payer ID Count	New - maximum 3 occurrences. Count of other payers with payment responsibility.
Response Coordination of Benefits/Other Payments	991-MH	Other Payer Processor Control Number	Required if other insurance information is available for coordination of benefits.
Response Coordination of Benefits/Other Payments	356-NU	Other Payer Cardholder ID	Required if other insurance information is available for coordination of benefits.
Response Coordination of Benefits/Other Payments	992-MJ	Other Payer Group Id	Required if other insurance information is available for coordination of benefits.
Response Coordination of Benefits/Other Payments	142-UV	Other Payer Person Code	Required if needed to uniquely identify the family members within the CardholderID, as assigned by the other payer.
Response Coordination of Benefits/Other Payments	127-UB	Other Payer Help Desk Phone Number	Required if needed to provide a support telephone number f the other payer to the receiver.
Response Coordination of Benefits/Other Payments	143-UW	Other Payer Patient Relationship Code	Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer.
Response Coordination of Benefits/Other Payments	144-UX	Other Payer Benefit Effective Date	Required when other coverage is known which is after the Date of Service submitted.
Response Coordination of Benefits/Other Payments	145-UY	Other Payer Benefit Termination Date	Required when other coverage is known which is after the Date of Service submitted.

NCPDP D.0
BILLING RE-BILL
SIZE CHANGES REPORT

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NCPDP D.0 Billing Re-Bill Gap Analysis
Size Changes

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Claim	402-D2	Prescription/Service Reference Number	field lengthened from 7 to 12 bytes
Claim	456-EN	Associated Prescription/Service Date Qualifier	field lengthened from 7 to 12 bytes. Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription.
Response Status	526-FQ	Additional Message Information	field length reduced from 200 to 40 bytes and added repeat functionality
Response Claim	402-D2	Prescription/Service Reference Number	field lengthened from 7 to 12 bytes

NCPDP D.0
BILLING RE-BILL
USE CHANGES REPORT

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NCPDP D.0 Billing Re-Bill Gap Analysis
Use Changes

Items in Red are flagged as Transitions Issues

Segment	Field	Description	D.0 Change Comment
Patient Segment	01		Segment requirement changed from optional to situational.
Claim	458-SE	Procedure Modifier Code Count	maximum occurrences increased to 10 removed the recommend number of occurrences with D.0, field lengthened from 1 to 2 bytes. Required if Procedure Modifier Code (459-ER) is used.
Pharmacy Provider Segment	02		Segment requirement changed from optional to situational.
Prescriber Segment	03		Segment requirement changed from optional to situational.
COB/ other payments Segment	05		Segment requirement changed from optional to situational.
COB/other payments	337-4C	Coordination of Benefits/Other Payments Count	maximum 9 occurrences recommended restriction of 3 or less was removed in D.0
COB/other payments	341-HB	Other Payer Amount Paid Count	maximum 9 occurrences and the recommended limitation verbiage was removed in D.0
COB/other payments	471-5E	Other Payer Reject Count	maximum 5 occurrences with D.0. Version 5.1 allowed a maximum of 20 with a recommended restriction of 5 or less.
DUR/PPS Segment	08		Segment requirement changed from optional to situational.
DUR/PPS	473-7E	DUR/PPS Code Counter	maximum 9 occurrences supported and recommended verbiage has been removed in D.0
Pricing	478-H7	Other Amount Claimed Submitted Count	maximum 3 occurrences with D.0 version 5.1 had a maximum of 9 recommended 3 occurrences or less.

Segment	Field	Description	D.0 Change Comment
Coupon Segment	09		Segment requirement changed from optional to situational.
Compound Segment	10		Segment requirement changed from optional to situational.
Compound	447-EC	Compound Route of Administration	maximum 25 ingredients in D.0 version 5.1 had maximum at 99 with 25 as recommended.
Clinical Segment	13		Segment requirement changed from optional to situational.
Clinical	491-VE	Diagnosis Code Count	maximum 5 occurrences with D.0 version 5.1 had maximum at 9 with 5 as recommended.
Clinical	493-XE	Clinical Information Counter	maximum 5 occurrences in D.0 version 5.1 allowed a maximum of 9 with 5 or less recommended.
Response Status	510-FA	Reject Count	maximum 5 occurrences in D.0 version 5.1 allowed a maximum of 99 with 5 or less recommended.
Response Status	547-5F	Approved Message Code Count	maximum 5 occurrences in D.0 version 5.1 had a maximum of 9 with 5 or less recommended.
Response Status	526-FQ	Additional Message Information	field length reduced from 200 to 40 bytes and added repeat functionality
Response Claim	551-9F	Preferred Product Count	maximum 6 occurrences in D.0 version 5.1 allowed maximum of 9 with 6 or less recommended.
Response Pricing	563-J2	Other Amount Paid Count	maximum 3 occurrences in D.0 version 5.1 allowed maximum of 9 with 3 or less recommended.
Response DUR/PPS	567-J6	DUR/PPS Response Code Qualifier	maximum 9 occurrences removed the recommended verbiage with D.0