Pharmacy Payment Provider Manual
ASC X12N 835
Version 5010X091A1

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Section 1.1 – CVS Caremark Pharmacy Payment Advice Introduction

In order to comply with federally mandated HIPAA regulations, CVS Caremark will utilize the ASC X12N Health Care Claim Payment Advice (835)/HIPAA Implementation Guide as the standard format for the electronic data interchange of electronic remittance advice (ERA).

Important Note: All references in this guide refer to the 835 HIPAA format. This guide should be used in conjunction with the ASC X12N National Electronic Interchange Transaction Set Implementation Guide for the 835 Health Care Claim Payment/Advice transaction set.

For more information on HIPAA please refer to the following companies, websites and publications:

HHS Administrative Simplification: http://aspe.hhs.gov/admnsimp/
Government Printing Office: http://www.access.gpo.gov/su_docs/aces/aces140.html
Washington Publishing Company http://wpc-edi.com/hipaa
CMS (centers for Medicare and Medicaid Services http://www.cms.gov/
NCPDP (National Council for Prescription Drug Programs) http://www.ncpdp.org
ANSI - American National Standards Institute http://www.ansi.org/
ASC X12 - Accredited Standards Committee X12 http://www.x12.org/
Phoenix Health Systems - HIPAAdvisory.com

Section 1.2 – CVS Caremark EDI Health Care Claim Payment Advice Overview

CVS Caremark offers the 835 Health Care Claim Payment Advice/ HIPAA Implementation in order to efficiently provide information to pharmacies by electronically transferring remittance information and pharmacy claims data to a pharmacy via EDI. The 835 presents the format and establishes the data contained in the Health Care Claim Payment Advice transaction set within the context of the EDI environment. The objective of the Health Care Claim Payment Advice is to provide pharmacies with a remittance advice to explain pharmacy claim payments. CVS Caremark will be providing the 835 pharmacy payment data in 80 byte fixed length, wrapped records.

Furthermore, the EDI Health Care Claim Payment Advice is intended for pharmacies to streamline their pharmacy claims data processing via EDI and comply with HIPAA. CVS Caremark uses the 835/ HIPAA Implementation exclusively to transmit pharmacy claims information subsequent to the adjudication of a claim, including reporting and adjustments of claims.
To eliminate system errors that have been occurring as a result of printable characters — tilde, asterisk, colon — being returned on the data file, the decision has been made to reassign non-printable Hex values as designated below.

From	To	Communications Definition	Delimiter
~ tilde	1E*	Record Separator = 1E	Segment
* asterisk	1D	Group Separator = 1D	Element
: colon	1F	Unit Separator = 1F	Sub-element

**Please note: If the data file is picked up from Secure Transport and is loaded to an MVS system or uses EBCDIC as its language, the processor of the data may receive a "35" as a record separator instead of the 1E.*

Section 1.3–CVS Caremark Contacts

The CVS Caremark Finance - Pharmacy Payments Department

WHAT YOU NEED	WHAT TO DO
To request another copy of the CVS Caremark provider manual.	Caremark835@caremark.com. If unavailable via Internet, contact CVS Caremark. 480-707-5692
To test Pharmacy Care Claim Payment Advice.	CVS Caremark Finance - Pharmacy Payments Department at 480-707-5692
Answers to pharmacy claim questions or to make payment adjustments…	The CVS Caremark Help Desk Arizona 800-345-5413 (BIN 610415) Texas 800-364-6331 (BIN 004336)
Answers to technical questions or to receive a duplicate file.	CVS Caremark Finance - Pharmacy Payments Department 480-707-5692
After implementing the Pharmacy Claim Payment Advice, to notify CVS Caremark of any changes.	CVS Caremark Finance - Pharmacy Payments Department 480-707-5692

Section 1.4 –
EDI & Telecommunications

The EDI translator converts application data to EDI formatted data or vice versa. There are several commercially available translator packages on the market based on your requirements. Pharmacies need to evaluate and select the translator that will best meet their needs.

The telecommunication link refers to the communication software package, the modem hardware, the Telephone line and the Value Added Network. There are many communication software packages on the market today that a pharmacy may select from to meet their individual requirements. A pharmacy should also select one of two types of phone lines, dial-up or direct. For most pharmacies dial-up is more than adequate. If data volume is very high, a direct line may be cost justified. For pharmacies already doing EDI with value-added networks VAN's, interconnection to these VANs may be available, but pharmacies will incur the cost of transmitting data through this network. CVS Caremark offers a variety of telecommunications connectivity options, including: (NDM) file transfer, and FTP (Internet). CVS Caremark will test the telecom link with the pharmacy to ensure proper connectivity.

Section 1.5 – Connectivity Testing

The objective of this phase is to test the telecommunication link between you and CVS Caremark. This test is not however to test the 835 standard data layout. A successful test will eventually occur if CVS Caremark is able to send an 835 to you. We do not require a 997 acknowledgement transaction set in return.

Section 1.6 – End-to-End Testing

The objective of this phase of the implementation is to ensure that all participants in the 835 electronic data interchange process are communicating with each other properly. This includes the pharmacy and CVS Caremark.

Section 1.7 – Move to Production & Maintenance

CVS Caremark requests at least eight weeks notification before a pharmacy is ready to receive the 835 transmissions. This time is required to allow CVS Caremark to prepare to send the transmissions, and for CVS CVS Caremark to ensure that the pharmacy data is properly entered in CVS Caremark systems.
Upon successful completion of the End-to End testing phase, the pharmacy will notify Caremark that they are ready to receive the 835 Health Care Claim Payment Advice via EDI. CVS Caremark will then establish the pharmacy into the production schedule and transmit the 835 to the pharmacy on a bi-weekly basis. If the pharmacy should encounter any EDI or 835 file problems or issues, they should contact their CVS Caremark representative for technical assistance at 480-707-5692.
When changes are made to the 835 Health Care Claim Payment Advice transaction set, CVS Caremark will provide the pharmacy with a notification of pending EDI Updates. These updates may or may not involve pharmacy partner location. CVS Caremark requires notification if there is a change in the representative or location to which EDI updates are being sent. Please submit these changes to your CVS Caremark EDI representative. For those pharmacies using EDI software packages customized for CVS Caremark, software updates are at the discretion of the software provider.

RECREATES: If the 835 transmission file needs to be recreated for any reason (i.e. Incomplete transmission, lost files, etc.), please contact your CVS Caremark representative. CVS Caremark reserves the right to charge for recreated files.

Section 1.8– 835 Description

The 835 transaction set has three main sections: Header, Detail and Summary. The Header section contains basic trading partner account information. The Detail section contains pharmacy claims information at the invoice level. The Summary section is used to mark the end of the transaction set.

Header Section
The Header section of the EDI Health Care Claim Payment Advice contains payment information, which is necessary for a financial institution to re-associate the 835 to the payment.

Detail Section
The Detail section of the EDI Health Care Claim Payment Advice contains payment advice information. This is information at the claim level, allowing the payee and payer to communicate to each other the specifics of what is being paid. The detail N1 segment should carry the company name, company division name or other organizational entity.

Summary Section
The Summary section of the EDI Health Care Claim Payment Advice is only used to identify the end of the transaction and related segment count balancing.

Section Layouts
For version 4010, the following documents are included:

1. **ASC X12 835 Technical Specification:** This document identifies the data segments CVS Caremark will use within the 835 transaction set.

2. **Summary ASC X12 835 Transaction Set:** This document shows all the segments at a summarized level that exist in the ASC standard for the 835 transaction and indicates whether that segment is required, how many times it can occur in the transaction, and how segments repeat (loop) relative to one another.

3. **Detail ASC X12 835 Transaction Set Layout:** This document shows all the 835 transaction set segments at a detail level. These segments are standardized organizations of like information, made up of units of data called data elements. This document shows what each segment element contains and how it is used by CVS Caremark.

Section 1.9 – 835 Transaction Set

835 Health Care Claim Payment/ Advice

HEADER

Interchange Control Header

SEG.	ID NAME		USAGE	REPEAT	LOOP REPEAT
ISA	Interchange Control Header	R	1		

Functional Group Header

SEG.	ID NAME	USAGE	REPEAT	LOOP REPEAT
GS	Functional Group Header	R	1	

Transaction Set Header

SEG.	ID NAME		USAGE	REPEAT	LOOP REPEAT
ST	Transaction Set Header	**R**	**1**		
BPR	Financial Information		**R**	**1**	
TRN	Reassociation Trace Number		**R**	**1**	
REF	Receiver Identification		**S**	**1**	
DTM	Production Date	**S**	**1**		

LOOP ID - 1000A PAYER IDENTIFICATION — **1**

SEG	ID NAME			
N1	Payer Identification	**R**	**1**	
N3	Payer Address	**R**	**1**	
N4	Payer City, State, ZIP Code	**R**	**1**	

LOOP ID – 1000B PAYEE IDENTIFICATION — **1**

SEG	ID NAME			
N1	Payee Identification	**R**	**1**	
N3	Payee Address	**S**	**1**	
N4	Payee City, State, ZIP Code	**S**	**1**	

Detail

LOOP ID – 2000 HEADER NUMBER — **>1**

SEG	ID NAME			
LX	Header Number	**S**	**1**	
TS3	Provider Summary Information		**S**	**1**

LOOP ID – 2100 CLAIM PAYMENT INFORMATION — **>1**

SEG	ID NAME		
CLP	Claim Payment Information	**R**	**1**
CAS	Claim Adjustment	**S**	**99**
NM1	Patient Name	**R**	**1**
NM1	Insured Name	**S**	**1**
DTM	Claim Date	**S**	**4**

LOOP ID – 2110 SERVICE PAYMENT INFORMATION — **999**

SVC	Service Payment Information		**S**	**1**
CAS	Service Adjustment		**S**	**99**
LQ	Health Care Remark Codes		**S**	**99**

Summary

LOOP ID – 2100 CLAIM PAYMENT INFORMATION

PLB	Provider Adjustment		**S**	**>1**
SE	Transaction Set Trailer		**R**	**1**

Section 1.10 – 835 Transaction Codes

Communications Transport Protocol/Envelope

Interchange Control Header

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
ISA- Interchange Control Header				**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
ISA01	Authorization Information Qualifier	I01	ID	(2/2)	Value = '00'	
ISA02	Authorization Information	I02	AN	(10/10)	Value = '1234567890'	
ISA03	Security Information Qualifier	I03	ID	(2/2)	Value = '00'	
ISA04	Security Information	I04	AN	(10/10)	Value = '1234567890'	
ISA05	Interchange ID Qualifier	I05	ID	(2/2)	Value = '14'	
ISA06	Interchange Sender ID	I06	AN	(15/15)	Value = DUNS + "0001" (7906630900001) for Scottsdale Value = DUNS + "0002" (7906630900002) for Dallas	
ISA07	Interchange ID Qualifier	I07	ID	(2/2)	Value = '30'	
ISA08	Interchange Receiver ID	I08	AN	(15/15)	Pharmacy Tax ID Number	
ISA09	Interchange Date	I09	DT	(6/6)	Value = Process Date	
ISA10	Interchange Time	I10	TM	(4/4)	Value = Process Time	
ISA11	Interchange Control Standards Identifier	I11	ID	(1/1)	Value = 'U'	
ISA12	Interchange Control Version Number	I12	ID	(5/5)	Value = '00401'	
ISA13	Interchange Control Number	I13	N0	(9/9)	Value = 0001 and increment by 1	
ISA14	Acknowledgement Requested	I14	ID	(1/1)	Value = 1 if telecom or internet	
ISA15	Usage Indicator	I15	ID	(1/1)	Value = P for production data	
ISA16	Component Element Separator	I16		(1/1)	Value = ":"	

Functional Group Header

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
GS - Functional Group Heading				**1**		**Required**
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
GS01	Functional Identifier Code	479	ID	(2/2)	Value = 'HP'	
GS02	Application Sender's Code	142	AN	(2/15)	Value = DUNS + "0001" (7906630900001) for Scottsdale Value = DUNS + "0002" (7906630900002) for Dallas	

GS03	Application Receiver's Code	124	AN	(2/15)	Pharmacy Tax ID Number
GS04	Date	373	DT	(8/8)	Value = Creation Date
GS05	Time	337	TM	(4/8)	Value = Creation Time
GS06	Group Control Number	28	N0	(1/9)	Value = 0001 and increment by 1
GS07	Responsible Agency Code	455	ID	(1/2)	Value = 'X'
GS08	Version/Release/Industry Identifier Code	480	AN	(1/12)	Value = 005010X091A1

Transaction Set Header

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
ST - Transaction Set Header				**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
ST01	Transaction Set Identifier	143	ID	(3/3)	Value = '835'	
ST02	Transaction Set Control Number	329	AN	(4/9)	Unique within each transmission. Will start with 0001 and be incremented by 1.	

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
BPR - Financial Information				**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
BPR01	Transaction Handling Code	305	ID	(1/2)	Value = "I" or "H"	
BPR02	Monetary Amount	782	R	(1/18)	Value = Total check amount	
BPR03	Credit/Debit Flag Code	478	ID	(1/1)	Value = 'C' (credit)	
BPR04	Payment Method Code	591	ID	(3/3)	Value = "CHK" or "NON" if balance is (-)	
BPR05	Payment Format Code	812	ID	(1/10)	N/A for Caremark	
BPR06	DFI ID Number Qualifier	506	ID	(2/2)	N/A for Caremark	
BPR07	DFI Identification Number	507	AN	(3/12)	N/A for Caremark	
BPR08	Account Number Qualifier	569	ID	(1/3)	N/A for Caremark	
BPR09	Account Number	508	AN	(1/35)	N/A for Caremark	
BPR10	Originating Company Identifier	509	AN	(10/10)	N/A for Caremark	
BPR11	Originating Company Supplemental Code	510	AN	(9/9)	N/A for Caremark	
BPR12	DFI ID Number Qualifier	506	ID	(2/2)	N/A for Caremark	
BPR13	DFI Identification Number	507	AN	(3/12)	N/A for Caremark	
BPR14	Account Number Qualifier	569	ID	(1/3)	N/A for Caremark	
BPR15	Account Number	508	AN	(1/35)	N/A for Caremark	
BPR16	Date	373	DT	(8/8)	Value = Check Date	

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
TRN – Re-association Trace Number				**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
TRN01	Trace Type Code	481	ID	(1/2)	Value = '1'	
TRN02	Reference Identification	127	AN	(1/30)	Check or EFT trace number. If no check is created this will populate with the cycle date plus a 2-byte sequence number. Example: 08100201 MMDDYYXX	

TRN03	Originating Company Identifier	509	AN	(10/10)	Value = RECAP 1752882129 (ADV/PWK/PMT/HZA) 1752882129 (EMP) 1237391136 (HZN) 1220999690 (PMI) 1680295375	
TRN04	Reference Identification	127	AN	(1/30)	Value = "0001" for Scottsdale "0002" for Dallas	
X12 - DED DESCRIPTION		**LOOP ID**		**REPEAT**	**LOOP REPEAT**	**USAGE**
REF - Receiver Identification				**1**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
REF01	Reference Identification Qualifier	128	ID	(2/3)	Value = 'EV'	
REF02	Reference Identification	127	AN	(1/30)	Value = Pharmacy Tax ID	
X12 - DED DESCRIPTION		**LOOP ID**		**REPEAT**	**LOOP REPEAT**	**USAGE**
DTM - Production Date				**1**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
DTM01	Date/Time Qualifier	374	ID	(3/3)	Value = '405'	
DTM02	Date	373	DT	(8/8)	Value = File Create Date in CCYYMMDD	

LOOP ID - 1000A PAYER IDENTIFICATION

X12 - DED DESCRIPTION		**LOOP ID**		**REPEAT**	**LOOP REPEAT**	**USAGE**
PAYER IDENTIFICATION		1000A PAYER IDENTIFICATION		**1**		
N1 - Payer Identification		1000A PAYER IDENTIFICATION		**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
N101	Entity Identifier Code	98	ID	(2/3)	Value = 'PR'	
N102	Name	93	AN	(1/60)	Value = 'Caremark'	
					Removed (N102 end of segment)	
X12 - DED DESCRIPTION		**LOOP ID**		**REPEAT**	**LOOP REPEAT**	**USAGE**
N3 - Payer Address		1000A PAYER IDENTIFICATION		**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
N301	Address Information	166	AN	(1/55)	Value = 9501 E. Shea Blvd.	
N302	Address Information	166	AN	(1/55)		
X12 - DED DESCRIPTION		**LOOP ID**		**REPEAT**	**LOOP REPEAT**	**USAGE**
N4 - Payer City, State, Zip Code		1000A PAYER IDENTIFICATION		**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
N401	City Name	19	AN	(2/30)	Value = Scottsdale	

N402	State or Province Code	156	ID	(2/2)	Value = AZ	
N403	Postal Code	116	ID	(3/15)	Value = 852606719	
X12 - DED DESCRIPTION		**LOOP ID**		**REPEAT**	**LOOP REPEAT**	**USAGE**
PAYEE IDENTIFICATION		1000A PAYEE IDENTIFICATION			**1**	
PER- Administrative Communications Contact		1000A PAYEE IDENTIFICATION		**1**		Required.
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
PER01	**Contact Function Code**	366	ID	**(2/2)**	Value = 'CX'	
PER02	**Payer Contact Name**	93	AN	**(1/60)**	Value = Pharmacy Help Desk	
PER03	**Communication Number Qualifier**	365	ID	**(2/2)**	Value = 'TE'	
PER04	**Communication Number**	364	AN	(**1/80)**	Value = 8003455413	
PER- Administrative Communications Contact		1000A PAYEE IDENTIFICATION		**1**		Required.
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
PER01	**Contact Function Code**	366	ID	**(2/2)**	Value = 'BL'	
PER02	**Payer Contact Name**	93	AN	**(1/60)**	Value = CVS Caremark	
PER03	**Communication Number Qualifier**	365	ID	**(2/2)**	Value = 'EM"	
PER04	**Communication Number**	364	AN	(**1/80)**	Value = Caremark835@caremark.com	

LOOP ID - 1000B PAYEE IDENTIFICATION

X12 - DED DESCRIPTION		**LOOP ID**		**REPEAT**	**LOOP REPEAT**	**USAGE**
PAYEE IDENTIFICATION		1000B PAYEE IDENTIFICATION			**1**	
N1 - Payee Identification		1000B PAYEE IDENTIFICATION		**1**		Required.
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
N101	Entity Identifier Code	98	ID	(2/3)	Value = 'PE'	
N102	Name	93	AN	(1/60)	Value = Name where check will be sent.	
N103	Identification Code Qualifier	66	ID	(1/2)	Value = 'FI'	
N104	Identification Code	67	AN	(2/80)	Value = Pharmacy Tax ID Number	
X12 - DED DESCRIPTION		**LOOP ID**		**REPEAT**	**LOOP REPEAT**	**USAGE**
N3 - Payee Address		1000B PAYEE IDENTICIATION		**1**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	

N301	Address Information	166	AN	(1/55)	Delivery destination; i.e., where the check will be sent.
N302	Address Information	166	AN	(1/55)	Delivery destination; i.e., where the check will be sent.

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
N4 - Payee City, State, Zip Code		1000B PAYEE IDENTICIATION		**1**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
N401	City Name	19	AN	(2/30)	Delivery destination; i.e., where the check will be sent.	
N402	State or Province Code	156	ID	(2/2)	Delivery destination; i.e., where the check will be sent.	
N403	Postal Code	116	ID	(3/15)	Delivery destination; i.e., where the check will be sent.	
N404	Country Code	26	ID	(2/3)	N/A for Caremark	

Detail

LOOP ID - 2000 HEADER INFORMATION

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
HEADER NUMBER		2000 HEADER NUMBER			**>1**	
LX - Assigned Number		2000 HEADER NUMBER		**1**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
LX01	Assigned Number	554	NO	(1/6)	Value = NCPDP Pharmacy Number	

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
TS3 - SUMMARY INFORMATION		2000 HEADER NUMBER		**1**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
TS301	Reference Identification	127	AN	(1/30)	Value = NPI Number + Check Digit	
TS302	Facility Code Value	1331	AN	(1/2)	Value =’99’	
TS303	Date	373	DT	(8/8)	Value = Last day of current year	
TS304	Quantity	380	R	(1/15)	Value = Total number of claims submitted for pharmacy. Includes paid, rejected, and adjustments.	
TS305	Monetary Amount	782	R	(1/18)	Value = Total submitted amount for claims in TS304 field.	
TS306	Monetary Amount	782	R	(1/18)	Not used	
TS307	Monetary Amount	782	R	(1/18)	Not used	
TS308	Monetary Amount	782	R	(1/18)	Not used	
TS309	Monetary Amount	782	R	(1/18)	Not used	

LOOP ID - 2100 CLAIM PAYMENT INFORMATION

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
CLAIM PAYMENT INFORMATION		2100 CLAIM PAYMENT INFORMATION			**>1**	
CLP - Claim Level Data		2100 Claim Payment Information		**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
CLP01	Claim Submitter's Identifier	1028	AN	(1/38)	Value = RX number	
CLP02	Claim Status Code	1029	ID	(1/2)	Value = 1 (claim is processed) Value = 4 (denied) Value = 5 (claim is pended) Value = 22 (claim is reversal)	
CLP03	Monetary Amount	782	R	(1/18)	Value = Gross Amount submitted. For paid, rejected, and detail adjustments.	
CLP04	Monetary Amount	782	R	(1/18)	Value = Gross Amount Paid.	
CLP05	Monetary Amount	782	R	(1/18)	Value = Patient responsibility. Patient co-pay.	
CLP06	Claim Filing Indicator Code	1032	ID	(1/2)	13 – Point of Sale	
CLP07	Reference identification	127	AN	(1/30)	Value = Document ID & Carrier/Group ID	
CLP08	Facility Code Value	1331	AN	(1/2)	N/A for Caremark	
CLP09	Claim Frequency Type Code	1325	ID	(1/1)	N/A for Caremark	
CLP10	Patient Status Code	1352	ID	(1/2)	Not Used	
CLP11	Diagnosis Related Group (DRG) Code	1354	ID	(1/4)	N/A for Caremark	
CLP12	Quantity	380	R	(1/15)	Metric Decimal Quantity	
CLP13	Percent	954	R	(1/10)	N/A for Caremark	
X12 - DED DESCRIPTION		**LOOP ID**		**REPEAT**	**LOOP REPEAT**	**USAGE**
CAS - Claim Adjustment		2100 Claim Payment Information		**99**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
CAS01	Claim Adjustment Group Code	1033	ID	(1/2)	CO = contractual obligations OA = other adjustments PR = patient responsibility	
CAS02	Claim Adjustment Reason Code	1034	ID	(1/5)	See Exhibit A	
CAS03	Monetary Amount	782	R	(1/18)	Value = adjustment net amount	
CAS04	Quantity	380	R	1/15)	N/A for Caremark	
CAS05	Claim Adjustment Reason Code	1034	ID	(1/18)	See Exhibit A	
CAS06	Monetary Amount	782	R	(1/18)	Value = adjustment net amount	
CAS07	Quantity	380	R	(1/15)	N/A for Caremark	
CAS08	Claim Adjustment Reason Code	1034	ID	(1/5)	See Exhibit A	

CAS09	Monetary Amount	782	R	(1/18)	Value = adjustment net amount
CAS10	Quantity	380	R	(1/15)	N/A for Caremark
CAS11	Claim Adjustment Reason Code	1034	ID	(1/5)	See Exhibit A
CAS12	Monetary Amount	782	R	(1/18)	Value = adjustment net amount
CAS13	Quantity	380	R	(1/15)	N/A for Caremark
CAS14	Claim Adjustment Reason Code	1034	ID	(1/15)	See Exhibit A
CAS15	Monetary Amount	782	R	(1/18)	Value = adjustment net amount
CAS16	Quantity	380	R	(1/15)	N/A for Caremark
CAS17	Claim Adjustment Reason Code	1034	ID	(1/5)	See Exhibit A
CAS18	Monetary Amount	782	R	(1/18)	Value = adjustment net amount
CAS19	Quantity	380	R	(1/15)	Not applicable for Caremark

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
NM1 – Patient Name		2100 Claim Payment Information		**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
NM101	Entity Identifier Code	98	ID	(2/3)	Value = 'QC'	
NM102	Entity Type Qualifier	1065	ID	(1/1)	Value = 1	
NM103	Name Last or Organization Name	1035	AN	(1/35)	Value = Last name of patient if provided. If not, then "not on file."	
NM104	Name First	1036	AN	(1/25)	Value = First name of patient if provided. If not, then "not on file."	
NM105	Name Middle	1037	AN	(1/25)	Not available	
NM106	Name Prefix	1038	AN	(1/10)	N/A for Caremark	
NM107	Name Suffix	1039	AN	(1/10)	N/A for Caremark	
NM108	Identification Code Qualifier	66	ID	(1/2)	Value = 'MI'	
NM109	Identification Code	67	AN	(2/80)	Value = Cardholder + suffix	

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
NM1 – Insured Name		2100 Claim Payment Information		**1**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
NM101	Entity Identifier Code	98	ID	(2/3)	Value = 'IL'	
NM102	Entity Type Qualifier	1065	ID	(1/1)	Value = 1	
NM103	Name Last or Organization Name	1035	AN	(1/35)	Value = Cardholder Last Name	
NM104	Name First	1036	AN	(1/25)	Value = Cardholder First Name	
NM105	Name Middle	1037	AN	(1/25)	Not available	
NM106	Name Prefix	1038	AN	(1/10)	N/A for Caremark	
NM107	Name Suffix	1039	AN	(1/10)	Not available	
NM108	Identification Code Qualifier	66	ID	(1/2)	Value = 'MI'	
NM109	Identification Code	67	AN	(2/80)	Value = Cardholder Id	
AMT01	Amount Qualifier Code	522	ID	**(1/3)**	**Value = I**	
AMT02	Monetary Amount	782	ID	**(1/18)**	**Value = Interest Amount**	
AMT03	Credit/Debit Flag Code	478	ID	**(1/1)**	**Not Used**	
X12 – Other Claim Related Identification	**2100**		Situational	**LOOP REPEAT**	**USAGE**	

REF01	Reference Identification Qualifier	128	ID	(2/3)	Value = '9C'	
REF02		Reference Identification	127	AN	(1/30)	Value = Reference ID
DTM – Claim Date		2100 Claim Payment Information		**4**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
DTM01	Date/Time Qualifier	374	ID	(3/3)	Value = 232	
DTM02	Date	373	DT	(8/8)	.**date the claim was received** CCYYMMDD format	
DTM – Claim Date		2100 Claim Payment Information		**4**		Situational
DTM01	Date/Time Qualifier	374	ID	(3/3)	Value = 050	
DTM02	Date/	373	DT	(8/8)	Claim received CCYYMMDD format	

LOOP ID - 2110 SERVICE PAYMENT INFORMATION

X12 - DED DESCRIPTION		**LOOP ID**		**REPEAT**	**LOOP REPEAT**	**USAGE**
SERVICE PAYMENT INFORMATION		2110 SERVICE PAYMENT INFORMATION			**999**	
SVC - Service Payment Information		2110 SERVICE PAYMENT INFORMATION		**1**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
SVC01	Medical Procedure Identifier	C003			Blank	
SVC01-1	Product/Service ID Qualifier	235	ID	(2/2)	Value = N4	
SVC01-2	Product/Service ID	234	AN	(1/48)	Value = NDC Number	
SVC01-3	Procedure Modifier	1339	AN	(2/2)	N/A for Caremark	
SVC01-4	Procedure Modifier	1339	AN	(2/2)	N/A for Caremark	
SVC01-5	Procedure Modifier	1339	AN	(2/2)	N/A for Caremark	
SVC01-6	Procedure Modifier	1339	AN	(2/2)	N/A for Caremark	
SVC01-7	Description	352	AN	(1/80)	N/A for Caremark	
SVC02	Monetary Amount	782	R	(1/18)	Submitted amount for Service	
SVC03	Monetary Amount	782	R	(1/18)	Amount paid For Service	
SVC04	Product/Service ID	234	AN	(1/48)	N/A for Caremark	
SVC05	Quantity	380	R	(1/15)	Quantity dispensed	
SVC06	Medical Procedure Identifier	C003			N/A for Caremark	
SVC06 - 1	Product/Service ID Qualifier	235	ID	(2/2)	Value = N4	
SVC06-2	Product/Service ID	234	AN	(1/48)	Value = NDC Number	
SVC06-3	Procedure Modifier	1339	AN	(2/2)	N/A for Caremark	
SVC06-4	Procedure Modifier	1339	AN	(2/2)	N/A for Caremark	
SVC06-5	Procedure Modifier	1339	AN	(2/2)	N/A for Caremark	
SVC06-6	Procedure Modifier	1339	AN	(2/2)	N/A for Caremark	
SVC06-7	Description	352	AN	(1/80)	N/A for Caremark	
SVC07	Quantity	380	R	(1/15)	N/A for Caremark	
X12 - DED DESCRIPTION		**LOOP ID**		**REPEAT**	**LOOP REPEAT**	**USAGE**
CAS - Service Adjustment		2110 Service Payment Information		**99**		Situational

REF DES.	NAME	DATA ELEMENT	TYPE	MIN/MAX	Additional Comments and Values
CAS01	Claim Adjustment Group Code	1033	ID	(1/2)	CO = contractual obligations OA = other adjustments PR = patient responsibility
CAS02	Claim Adjustment Reason Code	1034	ID	(1/5)	See Exhibit A. For service only
CAS03	Monetary Amount	782	R	(1/18)	Value = adjustment amount
CAS04	Quantity	380	R	(1/15)	N/A for Caremark
CAS05	Claim Adjustment Reason Code	1034	ID	(1/18)	See Exhibit A. For service only
CAS06	Monetary Amount	782	R	(1/18)	Value = adjustment amount
CAS07	Quantity	380	R	(1/15)	N/A for Caremark
CAS08	Claim Adjustment Reason Code	1034	ID	(1/5)	See Exhibit A. For service only
CAS09	Monetary Amount	782	R	(1/18)	Value = adjustment amount
CAS10	Quantity	380	R	(1/15)	N/A for Caremark
CAS11	Claim Adjustment Reason Code	1034	ID	(1/5)	See Exhibit A. For service only
CAS12	Monetary Amount	782	R	(1/18)	Value = adjustment amount
CAS13	Quantity	380	R	(1/15)	N/A for Caremark
CAS14	Claim Adjustment Reason Code	1034	ID	(1/15)	See Exhibit A. For service only
CAS15	Monetary Amount	782	R	(1/18)	Value = adjustment amount
CAS16	Quantity	380	R	(1/15)	N/A for Caremark
CAS17	Claim Adjustment Reason Code	1034	ID	(1/5)	See Exhibit A. For service only
CAS18	Monetary Amount	782	R	(1/18)	Value = adjustment amount
CAS19	Quantity	380	R	(1/15)	N/A for Caremark

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
LQ - Health Renmark Codes		2110 Service Payment Information		**99**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
LQ01	Code List Qualifier Code	1270	ID	(1/3)	Rx	
LQ02	Industry Code	1271	AN	(1/30)	NCPDP reject codes. **Exhibit C**	

Transaction Set Trailer

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
PLB - Provider Adjustment				**>1**		Situational
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
PLB01	Reference Identification	127	AN	(1/30)	Value = NPI Number + Check Digit	
PLB02	Date	373	DT	(8/8)	Last day of year CCYYMMDD	
PLB03	Adjustment Identifier	C042				
PLB03 -1	Adjustment Reason Code	426	ID	(2/2)	WO, CS, LS, WU, B2, IP, B3, AH, FB See **Exhibit B**	
PLB03 -2	Reference Identification	127	AN	(1/30)	See **Exhibit B**	
PLB04	Monetary Amount	782	R	(1/18)	Non claim related fee dollars	
PLB05	Adjustment Identifier	C042				
PLB05-1	Adjustment Reason Code	426	ID	(2/2)		
PLB05-2	Reference Identification	127	AN	(1/30)		
PLB06	Monetary Amount	782	R	(1/18)		
PLB07	Adjustment Identifier	C042				

PLB07-1	Adjustment Reason Code	426	ID	(2/2)	
PLB07-2	Reference Identification	127	AN	(1/30)	
PLB08	Monetary Amount	782	R	(1/18)	
PLB09	Adjustment Identifier	C042			
PLB09-1	Adjustment Reason Code	426	ID	(2/2)	
PLB09-2	Reference Identification	127	AN	(1/30)	
PLB10	Monetary Amount	782	R	(1/18)	
PLB11	Adjustment Identifier	C042			
PLB11-1	Adjustment Reason Code	426	ID	(2/2)	
PLB11-2	Reference Identification	127	AN	(1/30)	
PLB12	Monetary Amount	782	R	(1/18)	
PLB13	Adjustment Identifier	C042			
PLB13-1	Adjustment Reason Code	426	ID	(2/2)	
PLB13-2	Reference Identification	127	AN	(1/30)	
PLB14	Monetary Amount	782	R	(1/18)	

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
SE - Transaction Set Trailer				**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
SE01	Number of Included Segments	96	NO	(1/10)		
SE02	Transaction Set Control Number	329	AN	(4/9)	Value=0001 and increment by 1	

Functional Group Trailer

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
GE - Functional Group Trailer				**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
GE01	Number of Transaction Sets Included	97	N0	(1/6)		
GE02	Group Control Number	28	N0	(1/9)	Value=0001 and increment by 1	

Interchange Control Header

X12 - DED DESCRIPTION		LOOP ID		REPEAT	LOOP REPEAT	USAGE
IEA - Interchange Control Trailer				**1**		Required
REF DES.	**NAME**	**DATA ELEMENT**	**TYPE**	**MIN/MAX**	**Additional Comments and Values**	
IEA01	Number of Included Functional Groups	I16	N0	(1/5)	Value = Number of GS/GE segments within file.	
IEA02	Interchange Control Number	I12	N0	(9/9)	Value=0001 and increment by 1	

Communications Transport Trailer

	EXHIBIT A (3/2004)
http://www.wpc-edi.com/claimadjustment_40.asp	**HEALTH CARE CLAIM ADJUSTMENT REASON CODES X-REF TO VERSION 5 REJECT CODES FOR TELECOMMUNICATION STANDARD**
Health Care Claim Reject Codes	**Health Care Claim Reject Code Explanation**
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
18	Duplicate claim/service.

19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	Payment adjusted because charges have been paid by another payer.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your Stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	Coverage not in effect at the time the service was provided.
29	The time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility; spend down, waiting, or residency requirements.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
36	Balance does not exceed co-payment amount.
37	Balance does not exceed deductible.
38	Services not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
41	Discount agreed to in Preferred Provider contract.
42	Charges exceed our fee schedule or maximum allowable amount.

43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed your contracted/ legislated fee arrangement.
46	This (these) service(s) is (are) not covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
48	This (these) procedure(s) is (are) not covered.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a `medical necessity' by the payer.
51	These are non-covered services because this is a pre-existing condition
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case .
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed `proven to be effective' by the payer.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges adjusted as penalty for failure to obtain second surgical opinion.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
63	Correction to a prior claim.

64	Denial reversed per Medical Review.
65	Procedure code was incorrect. This payment reflects the correct code.
66	Blood Deductible.
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)
68	DRG weight. (Handled in CLP12)
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs.
71	Primary Payer amount.
72	Coinsurance day. (Handled in QTY, QTY01=CD)
73	Administrative days.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	Covered days. (Handled in QTY, QTY01=CA)
78	Non-Covered days/Room charge adjustment.
79	Cost Report days. (Handled in MIA15)
80	Outlier days. (Handled in QTY, QTY01=OU)
81	Discharges.
82	PIP days.
83	Total visits.
84	Capital Adjustment. (Handled in MIA)
85	Interest amount.
86	Statutory Adjustment.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
89	Professional fees removed from charges.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	Claim Paid in full.
93	No Claim level Adjustments.
94	Processed in Excess of charges.
95	Benefits adjusted. Plan procedures not followed.
96	Non-covered charge(s).
97	Payment is included in the allowance for another service/procedure.
98	The hospital must file the Medicare claim for this inpatient non-physician service.
99	Medicare Secondary Payer Adjustment Amount.

100	Payment made to patient/insured/responsible party.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
108	Payment adjusted because rent/purchase guidelines were not met.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled.
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
118	Charges reduced for ESRD network support.
119	Benefit maximum for this time period has been reached.
120	Patient is covered by a managed care plan.
121	Indemnification adjustment.
122	Psychiatric reduction.
123	Payer refund due to overpayment.
124	Payer refund amount - not our patient.

125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.
126	Deductible -- Major Medical
127	Coinsurance -- Major Medical
128	Newborn's services are covered in the mother's Allowance.
129	Payment denied - Prior processing information appears incorrect.
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this claim/service is pending further review.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
136	Claim Adjusted. Plan procedures of a prior payer were not followed.
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
140	Patient/Insured health identification number and name do not match.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
142	Claim adjusted by the monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment e.g. preferred product/service.
145	Premium payment withholding
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.

149	Lifetime benefit maximum has been reached for this service/benefit category.
150	Payment adjusted because the payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many services.
152	Payment adjusted because the payer deems the information submitted does not support this length of service.
153	Payment adjusted because the payer deems the information submitted does not support this dosage.
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.
A0	Patient refund amount.
A1	Claim denied charges.
A2	Contractual adjustment.
A3	Medicare Secondary Payer liability met.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive Payment Adjustment
A8	Claim denied; ungroupable DRG
B1	Non-covered visits.
B2	Covered visits.
B3	Covered charges.
B4	Late filing penalty.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.

B9	Services not covered because the patient is enrolled in a Hospice.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
B15	Payment adjusted because this procedure/service is not paid separately.
B16	Payment adjusted because `New Patient' qualifications were not met.
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
B19	Claim/service adjusted because of the finding of a Review Organization.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
B21	The charges were reduced because the service/care was partially furnished by another physician.
B22	This payment is adjused based on the diagnosis.
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
D1	Claim/service denied. Level of subluxation is missing or inadequate.
D2	Claim lacks the name, strength, or dosage of the drug furnished.

D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
D4	Claim/service does not indicate the period of time for which this will be needed.
D5	Claim/service denied. Claim lacks individual lab codes included in the test.
D6	Claim/service denied. Claim did not include patient's medical record for the service.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.
D8	Claim/service denied. Claim lacks indicator that `x-ray is available for review.'
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.
D10	Claim/service denied. Completed physician financial relationship form not on file.
D11	Claim lacks completed pacemaker registration form.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
D14	Claim lacks indication that plan of treatment is on file.
D15	Claim lacks indication that service was supervised or evaluated by a physician.

EXHIBIT B **Adjustment Reason Code(s)**

PLB 03 - 1	Code Description X12	**PLB 03 - 2**	Code Description (Caremark)
WO	Overpayment Recovery	1	Paid to Wrong Provider
CS	Adjustment (see IMP guide)	2	Ingredient Cost
LS	Lump Sum	3	Dispensing Fee
WU	Unspecified Recovery	4	Deductible / Copay
B2	Rebate	5	Sales Tax
IP	Incentive Premium Paid	6	Chargeback
B3	Recovery Allowance	7	Miscellaneous Lump Sum Charges
AH	Origination Fee	8	Correct Previous Adjustment
FB	Forward Balance	9	Claim Over Payment
		10	Void Pharmacy Check
		11	Research Fee

12	Membership/Imprinted Fee
13	Pharmacy Audit Recovery
14	Term Pharmacy Fee
15	EFT Reversal Recovery
16	Pre Note Recovery
17	EFT Returned Item
18	EFT PMT Correction
19	Pharmacy Overcharge
20	Pharmacy Billing
21	Cost of Goods
22	Order Processing Fee
23	Paid to Wrong Pharmacy Open Balance
24	Therapeutic Intervention
25	Puerto Rico Reform
26	Non-Compliance Penalty Fee
27	Non-Compliance Adjustment
28	Puerto Rico Rebate
29	GPIP
38	Pharmacy Recovery
39	Special Check
40	Claim Misbilled
41	Sponsor Recovery
42	RECAP transaction
43	Transaction Fee
44	Terminal Fee
45	Miscellaneous
46	Fee Sharing Debit
47	Fee Sharing Credit
48	Performance Fee Adjustment
49	Service Fee Adjustment
56	Pass-thru Performance Fee
57	Pass-thru Performance Fee Adjustment
58	GDP Adjustment
59	Transaction Based Subscription Fee Debit
60	Transaction Based Subscription Fee Credit
61	Advance Performance Network (APN)
MF	Management Fee
CF	Carry Forward Balance
BB	Beginning Balance

	Exhibit C		
NCPDP Reject Code	**NCPDP Reject Code Explanation**	**NCPDP Reject Code**	**NCPDP Reject Code Explanation**
00	("M/I" Means Missing/Invalid)	25	M/I Prescriber ID
01	M/I Bin	26	M/I Unit Of Measure
02	M/I Version Number	28	M/I Date Prescription Written
03	M/I Transaction Code	29	M/I Number Refills Authorized

04	M/I Processor Control Number	3A	M/I Request Type
05	M/I Pharmacy Number	3B	M/I Request Period Date-Begin
06	M/I Group Number	3C	M/I Request Period Date-End
07	M/I Cardholder ID Number	3D	M/I Basis Of Request
08	M/I Person Code	3E	M/I Authorized Representative First Name
09	M/I Birth Date	3F	M/I Authorized Representative Last Name
1C	M/I Smoker/Non-Smoker Code	3G	M/I Authorized Representative Street Address
1E	M/I Prescriber Location Code	3H	M/I Authorized Representative City Address
10	M/I Patient Gender Code	3J	M/I Authorized Representative State/Province Address
11	M/I Patient Relationship Code	3K	M/I Authorized Representative Zip/Postal Zone
12	M/I Patient Location	3M	M/I Prescriber Phone Number
13	M/I Other Coverage Code	3N	M/I Prior Authorized Number Assigned
14	M/I Eligibility Clarification Code	3P	M/I Authorization Number
15	M/I Date of Service	3R	Prior Authorization Not Required
16	M/I Prescription/Service Reference Number	3S	M/I Prior Authorization Supporting Documentation
17	M/I Fill Number	3T	Active Prior Authorization Exists Resubmit At Expiration Of Prior Authorization
19	M/I Days Supply	3W	Prior Authorization In Process
2C	M/I Pregnancy Indicator	3X	Authorization Number Not Found
2E	M/I Primary Care Provider ID Qualifier	3Y	Prior Authorization Denied
2Ø	M/I Compound Code	32	M/I Level Of Service
21	M/I Product/Service ID	33	M/I Prescription Origin Code
22	M/I Dispense As Written (DAW)/Product Selection Code	34	M/I Submission Clarification Code
23	M/I Ingredient Cost Submitted	35	M/I Primary Care Provider ID
		38	M/I Basis Of Cost
39	M/I Diagnosis Code	68	Filled After Coverage Expired
4C	M/I Coordination Of Benefits/Other Payments Count	69	Filled After Coverage Terminated
4E	M/I Primary Care Provider Last Name	7C	M/I Other Payer ID
40	Pharmacy Not Contracted With Plan On Date Of Service	7E	M/I DUR/PPS Code Counter

41	Submit Bill To Other Processor Or Primary Payer	70	Product/Service Not Covered
5C	M/I Other Payer Coverage Type	71	Prescriber Is Not Covered
5E	M/I Other Payer Reject Count	72	Primary Prescriber Is Not Covered
5Ø	Non-Matched Pharmacy Number	73	Refills Are Not Covered
51	Non-Matched Group ID	74	Other Carrier Payment Meets Or Exceeds Payable
52	Non-Matched Cardholder ID	75	Prior Authorization Required
53	Non-Matched Person Code	76	Plan Limitations Exceeded
54	Non-Matched Product/Service ID Number	77	Discontinued Product/Service ID Number
55	Non-Matched Product Package Size	78	Cost Exceeds Maximum
56	Non-Matched Prescriber ID	79	Refill Too Soon
58	Non-Matched Primary Prescriber	8C	M/I Facility ID
6C	M/I Other Payer ID Qualifier	8E	M/I DUR/PPS Level Of Effort
6E	M/I Other Payer Reject Code	80	Drug-Diagnosis Mismatch
6Ø	Product/Service Not Covered For Patient Age	81	Claim Too Old
61	Product/Service Not Covered For Patient Gender	82	Claim Is Post-Dated
62	Patient/Card Holder ID Name Mismatch	83	Duplicate Paid/Captured Claim
63	Institutionalized Patient Product/Service ID Not Covered	84	Claim Has Not Been Paid/Captured
64	Claim Submitted Does Not Match Prior Authorization	85	Claim Not Processed
65	Patient Is Not Covered	86	Submit Manual Reversal
66	Patient Age Exceeds Maximum Age	87	Reversal Not Processed
67	Filled Before Coverage Effective	88	DUR Reject Error
		89	Rejected Claim Fees Paid
90	Host hang up	CG	M/I Employer Street Address
91	Host Response Error	CI	M/I Employer State/Province Address
92	System Unavailable/Host Unavailable	CJ	M/I Employer Zip Postal Zone
95	Time Out	CK	M/I Employer Phone Number
96	Scheduled Downtime	CL	M/I Employer Contact Name
97	Payer Unavailable	CM	M/I Patient Street Address

98	Connection To Payer Is Down	CN	M/I Patient City Address
99	Host Processing Error	CO	M/I Patient State/Province Address
AA	Patient Spenddown Not Met	CP	M/I Patient Zip/Postal Zone
AB	Date Written Is After Date Filled	CQ	M/I Patient Phone Number
AC	Product Not Covered Non-Participating Manufacturer	CR	M/I Carrier ID
AD	Billing Provider Not Eligible To Bill This Claim Type	CW	M/I Alternate ID
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare	CX	M/I Patient ID Qualifier
AF	Patient Enrolled Under Managed Care	CY	M/I Patient ID
AG	Days Supply Limitation For Product/Service	CZ	M/I Employer ID
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients	DC	M/I Dispensing Fee Submitted
AJ	Generic Drug Required	DN	M/I Basis Of Cost Determination
AK	M/I Software Vendor/Certification ID	DQ	M/I Usual And Customary Charge
AM	M/I Segment Identification	DR	M/I Prescriber Last Name
A9	M/I Transaction Count	DT	M/I Unit Dose Indicator
BE	M/I Professional Service Fee Submitted	DU	M/I Gross Amount Due
B2	M/I Service Provider ID Qualifier	DV	M/I Other Payer Amount Paid
CA	M/I Patient First Name	DX	M/I Patient Paid Amount Submitted
CB	M/I Patient Last Name	DY	M/I Date Of Injury
CC	M/I Cardholder First Name	DZ	M/I Claim/Reference ID
CD	M/I Cardholder Last Name	EA	M/I Originally Prescribed Product/Service Code
CE	M/I Home Plan	EB	M/I Originally Prescribed Quantity
CF	M/I Employer Name	EC	M/I Compound Ingredient Component Count
ED	M/I Compound Ingredient Quantity	FO	M/I Plan ID
EE	M/I Compound Ingredient Drug Cost	GE	M/I Percentage Sales Tax Amount Submitted
EF	M/I Compound Dosage Form Description Code	HA	M/I Flat Sales Tax Amount Submitted
EG	M/I Compound Dispensing Unit Form Indicator	HB	M/I Other Payer Amount Paid Count
EH	M/I Compound Route Of Administration	HC	M/I Other Payer Amount Paid Qualifier

EJ	M/I Originally Prescribed Product/Service ID Qualifier	HD	M/I Dispensing Status
EK	M/I Scheduled Prescription ID Number	HE	M/I Percentage Sales Tax Rate Submitted
EM	M/I Prescription/Service Reference Number Qualifier	HF	M/I Quantity Intended To Be Dispensed
EN	M/I Associated Prescription/Service Reference Number	HG	M/I Days Supply Intended To Be Dispensed
EP	M/I Associated Prescription/Service Date	H1	M/I Measurement Time
ER	M/I Procedure Modifier Code	H2	M/I Measurement Dimension
ET	M/I Quantity Prescribed	H3	M/I Measurement Unit
EU	M/I Prior Authorization Type Code	H4	M/I Measurement Value
EV	M/I Prior Authorization Number Submitted	H5	M/I Primary Care Provider Location Code
EW	M/I Intermediary Authorization Type ID	H6	M/I DUR Co-Agent ID
EX	M/I Intermediary Authorization ID	H7	M/I Other Amount Claimed Submitted Count
EY	M/I Provider ID Qualifier	H8	M/I Other Amount Claimed Submitted Qualifier
EZ	M/I Prescriber ID Qualifier	H9	M/I Other Amount Claimed Submitted
E1	M/I Product/Service ID Qualifier	JE	M/I Percentage Sales Tax Basis Submitted
E3	M/I Incentive Amount Submitted	J9	M/I DUR Co-Agent ID Qualifier
E4	M/I Reason For Service Code	KE	M/I Coupon Type
E5	M/I Professional Service Code	M1	Patient Not Covered In This Aid Category
E6	M/I Result Of Service Code	M2	Recipient Locked In
E7	M/I Quantity Dispensed	M3	Host PA/MC Error
E8	M/I Other Payer Date	M4	Prescription/Service Reference Number/Time Limit Exceeded
E9	M/I Provider ID	M5	Requires Manual Claim
M6	Host Eligibility Error	PV	Non-Matched Associated Prescription/Service Date
M7	Host Drug File Error	PW	Non-Matched Employer ID
M8	Host Provider File Error	PX	Non-Matched Other Payer ID
ME	M/I Coupon Number	PY	Non-Matched Unit Form/Route of Administration
MZ	Error Overflow	PZ	Non-Matched Unit Of Measure To Product/Service ID
NE	M/I Coupon Value Amount	P1	Associated Prescription/Service Reference Number Not Found
NN	Transaction Rejected At Switch Or Intermediary	P2	Clinical Information Counter Out Of Sequence

PA	PA Exhausted/Not Renewable	P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions
PB	Invalid Transaction Count For This Transaction Code	P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions
PC	M/I Claim Segment	P5	Coupon Expired
PD	M/I Clinical Segment	P6	Date Of Service Prior To Date Of Birth
PE	M/I COB/Other Payments Segment	P7	Diagnosis Code Count Does Not Match Number Of Repetitions
PF	M/I Compound Segment	P8	DUR/PPS Code Counter Out Of Sequence
PG	M/I Coupon Segment	P9	Field Is Non-Repeatable
PH	M/I DUR/PPS Segment	RA	PA Reversal Out Of Order
PJ	M/I Insurance Segment	RB	Multiple Partials Not Allowed
PK	M/I Patient Segment	RC	Different Drug Entity Between Partial & Completion
PM	M/I Pharmacy Provider Segment	RD	Mismatched Cardholder/Group ID-Partial To Completion
PN	M/I Prescriber Segment	RE	M/I Compound Product ID Qualifier
PP	M/I Pricing Segment	RF	Improper Order Of 'Dispensing Status' Code On Partial Fill Transaction
PR	M/I Prior Authorization Segment	RG	M/I Associated Prescription/service Reference Number On Completion Transaction
PS	M/I Transaction Header Segment	RH	M/I Associated Prescription/Service Date On Completion Transaction
PT	M/I Workers' Compensation Segment	RJ	Associated Partial Fill Transaction Not On File
		RK	Partial Fill Transaction Not Supported
RM	Completion Transaction Not Permitted With Same 'Date Of Service' As Partial Transaction	TE	M/I Compound Product ID
RN	Plan Limits Exceeded On Intended Partial Fill Values	UE	M/I Compound Ingredient Basis Of Cost Determination
RP	Out Of Sequence 'P' Reversal On Partial Fill Transaction	VE	M/I Diagnosis Code Count
RS	M/I Associated Prescription/Service Date On Partial Transaction	WE	M/I Diagnosis Code Qualifier

RT	M/I Associated Prescription/Service Reference Number On Partial Transaction	XE	M/I Clinical Information Counter
RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment	ZE	M/I Measurement Date
R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions		
R2	Other Payer Reject Count Does Not Match Number Of Repetitions		
R3	Procedure Modifier Code Count Does Not Match Number Of Repetitions		
R4	Procedure Modifier Code Invalid For Product/Service ID		
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals Ø6		
R6	Product/Service Not Appropriate For This Location		
R7	Repeating Segment Not Allowed In Same Transaction		
R8	Syntax Error		
R9	Value In Gross Amount Due Does Not Follow Pricing Formula		
SE	M/I Procedure Modifier Code Count		