D.0 Pharmacy Claims Processing Manual

For the Michigan Department of Health and Human Services (MDHHS)
Medicaid
Children's Special Health Care Services (CSHCS)

Healthy Michigan Plan (HMP)
Maternity Outpatient Medical Services (MOMS)

Version 1.54

January 25, 2024

Revision History

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1.0	06/26/2006	Plan Administration	First updated version since 5.1 version effective August 14, 2003
1.1	08/08/2006	Plan Administration	Maintenance Drug List was updated, and the Payer Specifications was changed to reflect that MIC will be implemented at an undetermined future date
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			Updated Section 4.2.2 Required Data Elements Updated Section 4.4 Paper Claim – Universal Claim Form (UCF) Updated Section 7.5 Prior Authorization Table 8 Updated Section 7.6.2 Lock-In Beneficiaries Created Section 7.6.4 Emergency Services Only (ESO) Eligibility Updated Section 7.7 Managed Care Plans and Pharmacy Carve-Out Lists Updated Section 7.7.1 Pharmacy Carve-Outs Updated Section 7.7.2 Michigan Medicaid Health Plan Carve-Outs Removed Section 7.7.3 Adult Benefits Waiver-County Health Carve Out Updated Section 7.8 Compound Claims Removed Section 7.9 Home Infusion Therapy Claims Updated Section 7.3 Vaccine Submissions Updated Section 7.13.1 H1N1 Vaccine Updated Section 7.13.2 Seasonal Flu Vaccine Created Section 7.13.3 Other Vaccines Created Section 7.14 Professional Dispensing Fee Updated Section 8.1.1 Carrier ID List Updated Section 8.2.3 Medicare Part D Updated Appendix A – Payer Specifications for NCPDP D.0 Updated Appendix E – ProDUR Updated Appendix F – POS Reject Codes and Messages Updated Appendix G – Directory
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1.54	01/25/2024	Donna Johnson Documentation Mgmt	Updated Section 11.2.1 COVID-19 Vaccine Reimbursement Logic Updated Section 11.3 COVID-19 Vaccine Pharmacy Billing for Additional Doses and Place of Residence Administration Updated Appendix A – Payer Specifications for NCPDP D.0

Table of Contents

1.0 Introduction

1.1 MDHHS Pharmacy Programs

This manual provides claims submission guidelines for the following fee-for-service (FFS) pharmacy programs administered by the Michigan Department of Health and Human Services (MDHHS).

- Medicaid
- Children's Special Health Care Services (CSHCS)
- Healthy Michigan Plan (HMP)
- Maternity Outpatient Medical Services (MOMS)

Billing guidelines specified throughout this manual pertain to all programs, as do any references to Medicaid/MDHHS, unless specifically stated otherwise. Important MDHHS coverage and reimbursement policies are available in the Michigan Medicaid Provider

Manual and the Michigan Pharmaceutical Product List (MPPL). The Magellan Medicaid Administration website for MDHHS contains a link to these documents. Magellan Medicaid Administration is a division of Magellan Rx Management.

1.2 Pharmacy Benefit Manager – Magellan Medicaid Administration

The MDHHS contracts with Magellan Medicaid Administration as its pharmacy benefit manager to

- Adjudicate claims
- Distribute payment and remittance advices (RAs)
- Review prior authorization (PA) requests
- Perform prospective drug utilization review (ProDUR) and retrospective drug utilization review (RetroDUR)
- Conduct post-payment audits
- Provide clinical consultation
- Process batch files for claim reimbursement to health plans

2.0 Billing Overview and Background

2.1 Enrolling as an MDHHS-Approved Pharmacy

To enroll as a Medicaid pharmacy provider, the pharmacy must enroll via the Community Health Automated Medicaid Processing System (CHAMPS). Enrollment information can be found at http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_85441---,00.html or by calling 800-292-2550.

It is very important that a pharmacy provider update its information with the National Council on Prescription Drug Programs (NCPDP). NCPDP is the clearinghouse that provides pharmacy contact information to Magellan Medicaid Administration and ultimately to MDHHS. Current information is also required to comply with the Centers for Medicare & Medicaid Services (CMS) regulations and provide improved communication with MDHHS and Magellan Medicaid Administration. Pharmacy providers can update their information with NCPDP online at https://online.ncpdp.org/

Pharmacy providers may be terminated from the Michigan Medicaid network when address ownership changes, and any essential updates are not reported within the CMS required 35 days.

2.2 Magellan Medicaid Administration Website for MDHHS

Announcements, provider forms, drug information, provider manuals, bulletins, and drug look-up specifying covered drugs are posted on the Magellan Medicaid Administration website at https://michigan.magellanrx.com/. The following information can also be found:

- Michigan Medicaid Provider Manual link provides coverage, limitations, and reimbursement information.
- ePrescribing
- CoverMyMeds
- Drug Lookup

2.3 Important Contact Information

Refer to *Appendix G – Directory* at the end of this manual for important phone numbers, mailing addresses, and websites.

3.0 Magellan Medicaid Administration's Support Centers

Magellan Medicaid Administration has both a Pharmacy and Clinical Support Center to assist pharmacists and prescribers, as well as a Beneficiary Help Line that provides assistance to beneficiaries. *Appendix G – Directory* at the end of this manual, lists their phone numbers along with the hours of operation.

3.1 Pharmacy Support Center

1-877-624-5204 (Nationwide Toll-Free Number)

Magellan Medicaid Administration provides a toll-free number for pharmacies available 7 days a week, 24 hours a day, and 365 days a year. The Pharmacy Support Center responds to questions on coverage, claims processing, and beneficiary eligibility.

Examples of issues addressed by Pharmacy Support Center staff include, but are not limited to the following:

- Early Refills – Pharmacies may contact the Pharmacy Support Center for approval of early refills of a prescription.
- Questions on Claims Processing Messages – If a pharmacy needs assistance with alert or denial messages, it is important to contact the Pharmacy Support Center at the time of dispensing drugs. Magellan Medicaid Administration staff can provide claim information on all error messages, including messaging from the ProDUR system. Information includes the national drug codes (NDCs), drug names, the dates of service (DOS), the days' supply, and the NCPDP number of pharmacies receiving the ProDUR message(s).
- Clinical Issues – The Pharmacy Support Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. However, a second level of assistance is available if a pharmacist's question requires a clinical response. To address these situations, Magellan Medicaid Administration's pharmacists are available for consultation. Magellan Medicaid Administration uses reasonable care to accurately compile its ProDUR information. Since each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their patients.

3.2 Clinical Support Center

1-877-864-9014 (Nationwide Toll-Free Number)

Magellan Medicaid Administration provides a toll-free Clinical Support Center, available business days: Monday through Friday from 7:00 a.m. to 7:00 p.m. (with backup by the Pharmacy Support Center for other hours).

When prior authorization requests are denied, Clinical Support Center staff will mail notices of "adverse action" to the affected beneficiaries.

Examples of issues addressed by Clinical Support Center staff include, but are not limited to, the following:

- Prescribers – The Clinical Support Center handles prior authorization requests for non-preferred drugs, quantity limit overrides, and other situations. A pharmacy technician initially responds to callers. Requests not meeting established criteria or requiring an in-depth review are forwarded to a Magellan Medicaid Administration pharmacist.
- Pharmacies – The Clinical Support Center reviews requests for coinsurance payments on drugs normally covered by Medicare Part B and drug quantity limitations.

Note: The MDHHS approved manufacturer list is the same as the federal list found at https://data.medicaid.gov/Uncategorized/Drug-Manufacturer-Contacts/uex2-n56q/data.

The MDHHS Pharmaceutical Product List (MPPL), specifying covered drugs, is available at https://michigan.magellanrx.com/.

3.3 Beneficiary Help Line

1-877-681-7540 (Nationwide Toll-Free Number)

Beneficiaries with questions about their MDHHS pharmacy coverage may contact the Magellan Medicaid Administration Beneficiary Help Line. This line is available 7 days a week, 24 hours a day, 365 days a year. When questions are received about MDHHS eligibility, Magellan Medicaid Administration will refer beneficiaries to the MDHHS Beneficiary Help Line.

Note: The MDHHS Beneficiary Help Line is available at 1-800-642-3195. For individuals dually enrolled in Medicaid and Medicare (the duals), beneficiaries should be directed to 1-800-Medicare or to the help desk of their enrolled Medicare Part D prescription drug plan.

4.0 Program Setup

4.1 Claim Format

While Magellan Medicaid Administration strongly recommends claims submission by point-of-sale (POS), batch submission, and paper claims may be required for certain billings outside the norm. The following three Health Insurance Portability and Accountability Act (HIPAA) formats are accepted. Each is explained in subsequent sections.

Table 1 – Claim Formats Accepted by Magellan Medicaid Administration

Billing Media	NCPDP Version	Comments
POS	Version D.0	Online POS is preferred.
Batch	Batch 1.2	FTP is the preferred batch media.
Paper Claim	Universal Claim Form (D.0 UCF)	

4.2 Point-of-Sale – NCPDP Version D.0

Magellan Medicaid Administration uses an online POS system that allows enrolled pharmacies real-time online access to:

- Beneficiary eligibility
- Drug coverage
- Pricing
- Payment information
- ProDUR

The POS system is used in conjunction with a pharmacy's in-house operating system. While there are a variety of different pharmacy operating systems, the information contained in this manual specifies only the response messages related to the interactions with the Magellan Medicaid Administration online system and not the technical operation of a pharmacy's in-house-specific system. Pharmacies should check with their software vendors to ensure their system is able to process the payer specifications listed in *Appendix A – Payer Specifications for NCPDP D.0* of this manual.

4.2.1 Supported POS Transaction Types

Magellan Medicaid Administration has implemented the following NCPDP Version D.0 transaction types. A pharmacy's ability to use these transaction types will depend on its software. At a minimum, pharmacies should have the capability to submit original claims (B1), reversals (B2), and re-bills (B3). Other transactions listed on Table 2 – NCPDP Version D.0 Transaction Types Used for MDHHS Pharmacy Programs (although not currently used) may be available at a future date.

- Full Claims Adjudication (Code B1) – This transaction captures and processes the claim and returns the dollar amount allowed under the program's reimbursement formula. The B1 transaction will be the prevalent transaction used by pharmacies.
- Claims Reversal (Code B2) – This transaction is used by a pharmacy to cancel a claim that was previously processed. To submit a reversal, a pharmacy must void a claim that has received a PAID status and select the REVERSAL (Void) option in its computer system.
- Claims Re-Bill (Code B3) – This transaction is used by the pharmacy to adjust and resubmit a claim that has received a PAID status. A "claim re-bill" voids the original claim and resubmits the claim within a single transaction. The B3 claim is identical in format to the B1 claim with the only difference being that the transaction code (Field # 1Ø3) is equal to B3.

Note: The following fields must match the original paid claim for a successful transmission of a B2 (Reversal) or B3 (Re-Bill):

Service Provider ID – NCPDP Provider Number

- Prescription Number
- Date of Service (Date Filled)

Table 2 – NCPDP Version D.0 Transaction Types Used for MDHHS Pharmacy Programs

NCPDP D.0 Transaction Code	Transaction Name	MDHHS Transaction Support Requirements
E1	Eligibility Verification	Supported but not required
B1	Billing	Required
B2	Reversal	Required
B3	Re-Bill	Required
P1	Prior Authorization Request and Billing	May be required at a future date
P3	Prior Authorization Inquiry	May be required at a future date
P2	Prior Authorization Reversal	May be required at a future date

NCPDP D.0 Transaction Code	Transaction Name	MDHHS Transaction Support Requirements
P4	Prior Authorization Request Only	May be required at a future date
N1	Information Reporting	May be required at a future date
N2	Information Reporting Reversal	May be required at a future date
N3	Information Reporting Re-Bill	May be required at a future date
C1	Controlled Substance Reporting	May be required at a future date
C2	Controlled Substance Reversal	May be required at a future date
C3	Controlled Substance Reporting Re-Bill	May be required at a future date

4.2.2 Required Data Elements

A software vendor will need the Magellan Medicaid Administration payer specifications to set up a pharmacy's computer system to allow access to the required fields and to process claims. The Magellan Medicaid Administration claims processing system has program specific field requirements, e.g., mandatory, situational, and not sent. Table 3 – Definitions of Field Requirements Indicators Used in Payer Specifications lists abbreviations and that are used throughout the payer specifications to depict field requirements.

Table 3 – Definitions of Field Requirement Indicators Used in Payer Specifications

Code	Description
M	MANDATORY Fields with this designation according to NCPDP standards must be sent if the segment is required for the transaction.
R	REQUIRED Fields with this designation according to this program's specifications must be sent if the segment is required for the transaction.
RW	REQUIRED WHEN The situations designated have qualifications for usage ("Required if x," "Not required if y").
R***	REPEATING The "R***" indicates that the field is repeating. One of the other designators, "M" or "RW" will precede it.

MDHHS claims will not be processed without all the required (or mandatory) data elements. Required (or mandatory) fields may or may not be used in the adjudication process. Also, fields not required at this time may be required at a future date.

- Required Segments – The three transaction types implemented by Magellan Medicaid Administration have NCPDP-defined request formats or segments. Table 4 – Segments Supported for B1, B2, and B3 Transaction Types lists NCPDP segments used.

Table 4 – Segments Supported for B1, B2, and B3 Transaction Types

Segment	Transaction Type Codes		
	B1	B2	B3
Header	M	M	M
Patient	M	M	M
Insurance	M	RW	M
Claim	M	M	M
Prescriber	M	RW	M
COB/Other Payments	RW	RW	RW
DUR/PPS	RW	RW	RW
Pricing	M	M	M
Compound	RW	RW	RW
Clinical	RW	RW	RW
Trailer	M	M	M
M = Mandatory R = Required RW = Required when			

- Payer Specifications – A list of transaction types and their field requirements is available in the *Appendix A – Payer Specifications for NCPDP D.0*. These specifications list B1, B2, and B3 transaction types with their segments, fields, field requirement indicators (mandatory, situational, optional), and values supported by Magellan Medicaid Administration.
- MDHHS Program Setup – Table 5 – Important Required Values for MDHHS Program Setup lists required values unique to MDHHS programs.

Table 5 – Important Required Values for MDHHS Program Setup

Fields	Description	Comments
ANSI BIN #	ØØ9737	
Processor Control #	PØØ8009737	
Group #	MIMEDICAID	
Provider ID #	NPI	Ten digits, all numeric
Cardholder ID #	Michigan Beneficiary ID Number	Ten-digit Medicaid Health Insurance Number (may or may not have two zeros in front of the eight-digit Beneficiary ID)
Prescriber ID #	NPI number	Ten characters, all numeric Effective June 21, 2007: The dummy prescriber ID will no longer be allowed for claims submission. Please use a valid prescriber ID. If a physician's National Provider Identifier (NPI) is not available, you may not use your pharmacy NPI as an alternate.
Product Code	National Drug Code (NDC)	Eleven digits

4.3 NCPDP Batch Format 1.2

Pharmacies using batch processing primarily use file transfer protocol (FTP) transmissions. For record specifications and transmission requirements, pharmacies should contact the Magellan Medicaid Administration Electronic Media Claims Coordinator for FTP and the Pharmacy Support Center for other media types. Refer to *Appendix G – Directory* at the end of this manual for contact information and for mailing addresses for batch media.

4.4 Paper Claim – Universal Claim Form (UCF)

All paper pharmacy claims must be submitted to Magellan Medicaid Administration on a Universal Claim Form (UCF), which may be obtained from a pharmacy's wholesaler. The *Appendix G – Directory* at the end of this manual specifies:

- An alternative source for obtaining UCFs
- The Magellan Medicaid Administration address that pharmacies must use when sending completed UCF billings.

Completion instructions for the UCF are listed in *Appendix B – Universal Claim Form, Version D.0*. For certain billings outside the norm, Magellan Medicaid Administration may require or accept UCF submissions.

Examples of claims that a UCF may be submitted for include, but are not limited to the following:

- Prescriptions Exceeding the Timely Filing Limit – Paper claims are allowed when the timely filing limit is exceeded. It is the pharmacy's responsibility to obtain an authorization override prior to submitting the paper claims. Paper claims requiring authorization overrides that are submitted without the pharmacy first obtaining the authorization override, will be returned to the pharmacy without being processed.

  Note: Claims exceeding the timely filing limit may also be submitted via POS. Authorization will still be required

- Other Exceptions for MOMS – Magellan Medicaid Administration will accept paper claims if a pharmacy is unable to process a claim electronically because a beneficiary's eligibility record has not been updated. For these situations, paper claims received from the pharmacy should document that eligibility verification problems exist or provide documentation, such as the MOMS Guarantee of Payment Letter to show proof of eligibility. If within 30 days from the date the claim was received by Magellan Medicaid Administration, the beneficiary's eligibility has not been loaded in the Magellan Medicaid Administration system, Magellan Medicaid Administration will forward the claim and supporting documentation to MDHHS for review and resolution.

5.0 Service Support

5.1 D.0 Online Certification

The Software Vendor/Certification Number (NCPDP Field # 11Ø-AK) of the Transaction Header Segment is required for claim submission under NCPDP Version D.0. Magellan Medicaid Administration certifies software vendors, not an individual pharmacy's computer system. A pharmacy should contact its vendor or Magellan Medicaid Administration to determine if the required certification has been obtained. For assistance with software vendor certification, contact Magellan Medicaid Administration at 804-2177900. Refer to *Appendix G – Directory* at the end of this manual for other contact information.

5.2 Electronic Funds Transfer (EFT)

Magellan Medicaid Administration provides an EFT payment option. To request EFT, a pharmacy must complete the Electronic Transfer Authorization Form available at https://michigan.magellanrx.com/. Select the link to Provider and then Forms. The completed form must be returned to the Magellan Medicaid Administration Provider Operations Department. Refer to *Appendix G – Directory* at the end of this manual for contact information. In addition, you can go to https://eftera.magellanrx.com/ and select the EFT link to submit the application online. The website will only allow users to submit EFT or ERA applications, not allow them to view or update existing EFT/ERA information.

EFT payments will begin no sooner than 16 days after receipt of the completed form. Payments will be transferred to the pharmacy's designated banking account every Monday and will be available within 24 to 48 hours. If an EFT fails, Magellan Medicaid Administration will reissue a paper check within 10 business days of the original settlement. A pharmacy may contact the Magellan Medicaid Administration Provider Operations Department to (1) update name, address, financial institution, and account information or (2) discontinue EFT payments.

5.3 Electronic Remittance Advice

Magellan Medicaid Administration accommodates the HIPAA ANSI X12 835, Version 5010 A1, for remittance advices. This format replaces the proprietary electronic version previously used.

Magellan Medicaid Administration requires any entity (including pharmacies and health plans) attempting to access its firewall to be registered as a service center. To become a registered service center, an entity must have a fully executed Electronic Data Interchange Trading Partner Agreement on file with Magellan Medicaid Administration and submit an Electronic Transactions Agreement to Receive X12 835 Electronic Remittance Advices for Service Centers, EDI Form-P835, for each state with which the service center desires to do business. These forms are available at https://eftera.magellanrx.com/ and can be submitted online. Click the **ERA** button to submit the application online. The website will only allow users to submit EFT or ERA applications, not allow them to view or update existing EFT/ERA information.

Completed forms and questions on approval status should be forwarded to the Magellan Medicaid Administration Electronic Media Claims (EMC) Coordinator by fax 1-888-656-4139 or at the address below. Providers with questions can call 1-800-924-6741.

Magellan Medicaid Administration, Inc.

Media Control/Michigan EMC Processing Unit

11013 West Broad Street Suite 500 Glen Allen, VA 23060

Upon receipt of the forms above, Magellan Medicaid Administration will call the contact named on Form-P835 and will provide a login ID, password, and other requirements for access to their secure FTP site.

5.4 Solving Technical Problems

Pharmacies will receive one of the following messages when the Magellan Medicaid Administration POS system is down:

Table 6 – Host System Problem Messages and Explanations

NCPDP	Message	Explanation
90	Host Hung Up	Host disconnected before session completed.
92	System Unavailable/Host Unavailable	Processing host did not accept transaction or did not respond within time out period.
93	Planned Unavailable	Transmission occurred during scheduled downtime. Scheduled downtime for file maintenance is Sunday 11:00 p.m.–6:00 a.m. ET
99	Host Processing Error	Do not retransmit claims.

Magellan Medicaid Administration strongly encourages that a pharmacy's software has the capability to submit backdated claims. Occasionally, a pharmacy may also receive messages that indicate its own network is having problems communicating with Magellan Medicaid Administration.

If this occurs, or if a pharmacy is experiencing technical difficulties connecting with the Magellan Medicaid Administration system, pharmacies should follow the steps outlined below:

1. Check the terminal and communications equipment to ensure that electrical power and telephone services are operational.
2. Call the telephone number the modem is dialing and note the information heard (i.e., fast busy, steady busy, recorded message).
3. Contact the software vendor if unable to access this information in the system.
4. If the pharmacy has an internal technical staff, forward the problem to that department, then internal technical staff should contact Magellan Medicaid Administration to resolve the problem.
5. If unable to resolve the problem after following the steps outlined above, directly contact the Magellan Medicaid Administration Pharmacy Support Center. Refer to *Appendix G – Directory* at the end of this manual for contact information.

6.0 Online Claims Processing Edits

After online claim submission is made by a pharmacy, the POS system will return a message to indicate the outcome of processing. If the claim passes all edits, a PAID message will be returned with the allowed reimbursement amount. A claim that fails an edit and is REJECTED (or DENIED) will also return with a NCPDP rejection code and message. Refer to *Appendix F – POS Reject Codes and Messages* for a list of POS rejection codes and messages.

7.0 Program Specifications

7.1 Timely Filing Limits

Most pharmacies that utilize the POS system submit their claims at the time of dispensing drugs. However, there may be mitigating reasons that require a claim to be submitted retroactively.

- CI = 180 days. Prescription good for 90 days from date written
- CII = 365 days. Prescription good for 90 days from date written
- CIII – CIV = 365 days. Prescription good for 180 days from date written or 5 refills, whichever first
- CV = 365 days. Prescription good for 365 days from date written
- Non-Controls = 365 days. Prescription good for 365 days from date written
- Partial fills = 60 days (CII – CV = 365 days)

7.1.1 Overrides

For overrides on claims, reversals, and adjustments billed past the timely filing limits of 180 days or more, pharmacies must contact the Pharmacy Support Center. Refer to *Appendix G – Directory* at the end of this manual for contact information. Approved criteria for Magellan Medicaid Administration to override the denials include

- Retroactive beneficiary eligibility
- Third-party liability (TPL) delay
- Retroactive disenrollment from Medicaid health plan
- Claims recovered through rebate dispute resolution as identified and agreed upon by the rebate manufacturers and the MDHHS staff. Magellan Medicaid Administration may also override claims discovered through rebate dispute resolution as identified and agreed upon by the Magellan Medicaid Administration Rebate and the MDHHS staff.

7.2 Days' Supply and Maintenance Drug List

Days' supply information is critical to the edit functions of the ProDUR system. Submitting incorrect days' supply information may cause false positive ProDUR messages or claim denial for that particular claim or for claims that are submitted in the future.

Information on MDHHS's dispensing policies can be found in the Pharmacy chapter of the Michigan Medicaid Provider Manual. A maximum supply of 102 days is allowed for selected therapeutic classes. Refer to *Appendix C – MDHHS Maintenance Drug List* for a listing of these maintenance classes. Please note that certain drugs may have specific quantity limits that supersede this list as identified in the Michigan Pharmaceutical Product List (MPPL). Beneficiary specific prior authorization is required when requesting a maintenance quantity for other drugs.

7.3 Schedule II Refills

According to the Michigan Board of Pharmacy, a pharmacist may partially dispense a controlled substance designated as Schedule II. If a pharmacist is unable to supply the full amount ordered in a written or emergency oral prescription, the pharmacist makes a notation of the quantity supplied on the face of the written prescription or written record of the emergency oral prescription. Except as noted below, the remainder of the prescription may be dispensed within 72 hours of the first partial dispensing. If the remainder is not or cannot be dispensed within the 72-hour period, the pharmacy must notify the prescriber and additional quantities must not be dispensed beyond the 72-hour period without a new prescription. Magellan Medicaid Administration supports the following procedures for partial dispensing of Schedule II drugs.

7.3.1 Retail Schedule II Prescriptions

The pharmacy must not charge MDHHS an additional dispensing fee for filling the remainder of a partially dispensed Schedule II prescription.

7.3.2 Schedule II Prescriptions for Individuals in Long-Term Care (LTC) Facilities or Beneficiaries with a Terminal Illness

Prescriptions for Schedule II controlled substances that are written (1) for a beneficiary in a long-term care facility or (2) for a beneficiary with a medical diagnosis that documents a terminal illness may be filled in partial quantities, including individual dosage units.

- The pharmacy may not charge MDHHS an additional dispensing fee for filling the remainder of a partially dispensed Schedule II prescription.
- The quantity dispensed in all partial fillings must not exceed the total quantity prescribed.

- For each partial filling, the pharmacy must record on the back of the prescription or on another appropriate record that is uniformly maintained and readily retrievable, all the following information:
  - Date of the partial filling
  - Quantity dispensed
  - Remaining quantity authorized to be dispensed
  - Identification of the dispensing pharmacist
  - Whether the patient was terminally ill or residing in a long-term care facility

Note: According to the Michigan Board of Pharmacy, Schedule II prescriptions for a patient in a long-term care facility or for a patient with a medical diagnosis that documents a terminal illness shall be valid for not more than 60 days from the issue date, unless terminated at an earlier date by the discontinuance of the medication.

7.4 Maximum Allowable Cost (MAC) Rates

MDHHS has MAC reimbursement levels generally applied to multi-source brand and generic products. However, MAC reimbursement may also be applied to single-source drugs or drug classifications. Refer to the *MDHHS Medicaid Provider Manual* for additional information.

The Magellan Medicaid Administration website at https://michigan.magellanrx.com/ provides links to new or changed MAC rates. The files on the website are provided as a convenience only to pharmacies to assist them with pre-POS adjudication decision making. The presence of a particular drug on the website MAC lists does not guarantee payment or payment level. The POS system provides up-to-date MAC information.

- Antihemophilic Factors – Click the link to **Provider/Documents/Drug Pricing/Clotting Factor MAC Pricing**.
- Other MACs – Click the link to **Provider/Documents/Drug Pricing, MAC Listing or MAC Listing (Weekly Changes)**.

7.4.1 MAC Pricing or Appeal/Raise Issues

Providers can check MAC prices for all drugs that have a MAC, by going to https://michigan.magellanrx.com/. Select the link to Provider/Documents/Drug Pricing.

Appeal/Raise MAC pricing issues are

- Dispense As Written (DAW) Pricing – To request reimbursement for the brand and if the script is written as "DAW," please refer to DAW override requirements.
- MAC Price Review Requests – Please refer to https://michigan.magellanrx.com/ website as noted above and click, Provider/Documents/ Drug Pricing/MAC Price Research Request Form. This will open a form that the user can fill out and submit directly to Magellan Medicaid Administration for a MAC price review.

7.4.2 MAC Overrides

A beneficiary must not be required to pay a MAC penalty (the difference between the brand name and the generic products). To receive payment above a MAC rate, prior authorization through Magellan Medicaid Administration must be obtained. None of the DAW codes (see *Table 7 – NCPDP DAW Code Values*) alone will override a MAC rate at the point-of-sale.

Table 7 – NCPDP DAW Code Values

DAW Code	Explanation
0	No product selection indicated
1	Substitution not allowed by prescriber
2	Substitution allowed – patient requested product dispensed
3	Substitution allowed – pharmacist selected product dispensed
4	Substitution allowed – generic product not in stock
5	Substitution allowed – brand drug dispensed as a generic
6	Override
7	Substitution not allowed – brand mandated by law
8	Substitution allowed – generic drug unavailable in the marketplace
9	Other

Pharmacies should note the following Magellan Medicaid Administration claims processing logic that applies when a MAC exists, and

- If DAW 1 is submitted and PA is on file for the beneficiary, the claim will reimburse at the brand name rate instead of the MAC.
- If DAW 1 is not submitted and PA is on file for a beneficiary, the claim will pay with logic that includes MAC price. The MAC will not be overridden.
- If DAW 2 is submitted, and the medication has a MAC price, the claim will deny unless PA is on file for the beneficiary. DAW 2 (the patient requested the product) will not substantiate PA for a MAC override.

7.5 Prior Authorization

The PA process is designed to provide rapid and timely responses to requests. PAs are managed by three ways: pharmacy level overrides, the Clinical Support Center, and the Pharmacy Support Center. Support centers are described under *Section 3.0 – Magellan Medicaid Administration's Support Centers* in this manual and contact information is listed in *Appendix G – Directory* at the end of this manual. Table 8 – Prior Authorization Procedures lists examples of various prior authorization procedures. The Magellan Medicaid Administration support centers are responsible for reviewing requests. The health care provider is responsible for obtaining prior authorization.

Table 8 – Prior Authorization Procedures

Examples of PA Products or Edit Types	Where to Call	Who Should Call
Drugs Not Listed on the Michigan Pharmaceutical Product List (MPPL) Drugs Listed on the Michigan Pharmaceutical Product List as Requiring PA	Clinical Support Center	Prescribers
MAC Price Overrides MACs are set on multiple source drugs and some therapeutic classes. Payment for product cost will not exceed a drug's MAC price regardless of the brand dispensed unless PA is granted.	Clinical Support Center	Prescribers
Quantity Limitations	Clinical Support Center	Pharmacies or Prescribers
Cost Sharing Payments for Medicare Part B Covered Drugs	Clinical Support Center	Pharmacies
Rounding Edit Magellan Medicaid Administration codes for certain drugs to only allow whole multiples of the package size	Clinical Support Center	Pharmacies

Examples of PA Products or Edit Types	Where to Call	Who Should Call
Narcotics – Early Refills MDHHS Policy implemented 11/01/07 Increase the refill tolerance to 10 percent (requiring 90 percent of the days' supply to be used) for the H3A – Narcotic Analgesics for all beneficiaries. • Include more specific transaction message to the pharmacy on the NCPDP 88 indicating 10 percent refill tolerance – H3A Narcotic Analgesics. • Exclusions from this new edit: – Beneficiaries with LOC = 16 (they will continue with the 25 percent refill tolerance) – COB claims with > $0 reported as paid by Other Insurance (i.e., OCC – 2 and Payment Collected > $0) – LOC = 13 or 14 (they will continue with the 5 percent refill tolerance)	Pharmacy Support Center	Pharmacies
Early Refills for Ambulatory Beneficiaries Each claim submitted is evaluated to determine if at least 75 percent of the previous fill of the same drug product has been used. Claims will deny at the POS if the utilization requirement has not been met.	Pharmacy Support Center	Pharmacies
Early Refills for LTC Beneficiaries An exception is allowed, when the Early Refill edit is hitting because of an LTC new admission or a readmission.	Pharmacy Level Override	Pharmacies may override PA by entering a Submission Clarification Code = 05. If the beneficiary is not flagged as an active LTC beneficiary, the claim will deny.

7.6 Special Eligibility Situations

7.6.1 Newborns

The newborn's Medicaid ID number must be transmitted on the pharmacy claim. If the newborn's Medicaid ID number is not available, contact the MDHHS Enrollment Services Section. The parent's ID cannot be used in place of the newborn. Refer to the *Directory Appendix* in the Michigan Medicaid Provider Manual.

7.6.2 Lock-In Beneficiaries

For information regarding lock-in beneficiaries, also referred to as Benefit Monitoring Program (BMP), refer to the *Beneficiary Eligibility* chapter in the *Michigan Medicaid Provider Manual*.

7.6.3 Retroactive Eligibility

Pharmacies may bill for prescriptions dispensed to beneficiaries who become retroactively eligible for Medicaid. Pharmacies must contact the Pharmacy Support Center to obtain approval for retroactive prior authorization or timely filing overrides in cases when eligibility was retroactive. Medications that require prior authorization will still require an override.

An authorization will not be granted unless criteria is met even in cases of retro-eligibility.

7.6.4 Emergency Services (ESO) Eligibility

Effective 10/01/2017, claims submitted for beneficiaries covered under any ESO program will deny unless the pharmacy submits a level of service = 03, which by submitting attests that the medication being dispensed is for an emergent conditioned as outlined in the Medicaid Provider Manual, Emergency Services Only Chapter.

7.7 Managed Care Plans and Pharmacy Carve-Out Lists

MDHHS contracts with capitated managed care plans to provide services for its beneficiaries. These plans are responsible for most pharmacy services. Carve-out exceptions are explained in the next sections. Approved Medicaid Health Plan (MHP) pharmaceutical products may differ from Medicaid FFS and CSHCS programs. Refer to the *Pharmacy* chapter, *Medicaid Health Plan (MHP)* section in the *Michigan Medicaid Provider Manual*. Information regarding the MHP common formulary can be found at https://www.michigan.gov/documents/mdhhs/Managed_Care_Common_Formulary_Listing_506275_7.pdf.

7.7.1 Pharmacy Carve-Outs

Selected drugs and classes are carved out from the managed care plan coverage and are paid directly to a pharmacy by the MDHHS fee-for service program. For these drugs, pharmacies must bill Magellan Medicaid Administration for reimbursement.

The Magellan Medicaid Administration website at https://michigan.magellanrx.com/ includes the carve-out lists for Medicaid health plans.

7.7.2 Michigan Medicaid Health Plan Carve-Outs

Pharmacies will not be reimbursed for prescriptions dispensed to beneficiaries enrolled in the Medicaid health plans, except for drugs designated as carve-out.

If a pharmacy bills Magellan Medicaid Administration for drug products not designated as carve-out, the claim will be denied with a transaction message to bill the Medicaid health plan.

7.8 Compound Claims

Refer to the *Pharmacy* chapter of the *Michigan Medicaid Provider Manual* for information and reimbursement rates. To request the compounded dispensing fee from the POS system, pharmacies must:

- Enter COMPOUND CODE (NCPDP Field # 4Ø6-D6) of "2."
- Enter PRODUCT CODE/NDC (NCPDP Field # 4Ø7-D7) as "0" on the claim segment to identify the claim as a multi-ingredient compound.
- Enter QUANTITY DISPENSED (NCPDP Field # 442-E7) of entire product.
- Enter GROSS AMOUNT DUE (NCPDP Field # 43Ø-DU) for entire product.
- Enter the following fields on the COMPOUND SEGMENT:
  - COMPOUND DOSAGE FORM DESCRIPTION CODE (NCPDP Field # 45Ø-EF)
  - COMPOUND DISPENSING UNIT FORM INDICATOR (NCPDP Field # 451-EG)
  - COMPOUND INGREDIENT COMPONENT COUNT (NCPDP Field # 447-EC) (Maximum of 99)
  - COMPOUND PRODUCT ID QUALIFIER (NCPDP Field #488-RE) of "3"
  - COMPOUND PRODUCT ID (NCPDP Field # 489-TE)
  - COMPOUND INGREDIENT QUANTITY (NCPDP Field # 448-ED)
  - COMPOUND INGREDIENT COST (NCPDP Field # 449-EE)

- SUBMISSION CLARIFICATION CODE (NCPDP Field # 42Ø-DK) = Value "8" will only be permitted for POS claims and will allow a claim to continue processing if at least one ingredient is covered with reimbursement for the covered product only. Batch claims from the Medicaid health plans will need to be submitted for covered ingredients only or the claim will deny as they cannot submit submission clarification code "8," they must submit "99" in that field. Any compound claims that contain any NDC within the Compound Exclusion List will deny. Claim will need to be resubmitted with the excluded ingredient removed.

  Note: The order of the NDC does not matter. For billing questions or concerns, please refer to the *MDHHS Policy Bulletin*, which is available at https://michigan.magellanrx.com/.

  – Providers must submit the following for each compound ingredient specified:
    - Compound Product ID Qualifier
    - Compound Product ID field with the appropriate values – do not include null or spaces in this field.
    - Compound Ingredient Cost field with an amount great than zero.
    - At least two NDCs must be billed in the compound segment for compound submissions. If there are not two NDCs, claims will reject for NCPDP 20 – M/I compound code
  – MDHHS will not accept Compound Route of Administration value "0" as a valid value. Please refer to *Appendix A – Payers Specifications for NCPDP D.0* for the new route of administration in the claim segment and the new acceptable values.

    Note: Ora-Plus, Ora-Blend, Baclofen, Co-Enzyme Q10, cherry syrup, and bulk powders are covered in compounds if the NDC is rebateable and included in the weekly First Databank (FDB) drug reference file. All other powder products require a non-formulary prior authorization.

  Note: National Drug Codes that are not included in the weekly FDB drug reference file are non-covered by MDHHS.

7.9 Home Infusion Therapy Claims

MDHHS reimburses each home infusion claim with a professional dispensing fee of $20.02. Coverage of home infusion therapy claims is limited to products that are not oral therapies.

To ensure home infusion therapy claims are processed successfully, pharmacies must:

- Enter **8** in the 12-digit prior authorization type code (NCPDP Field # 461-EU) of the claim segment.
- Please note that there is a maximum of 13 professional dispensing fees paid in a rolling 365-day period for same pharmacy and same drug/home infusion.

Refer to the MDHHS Medicaid Provider Manual for more information:
http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

7.10 Unit Dose Claims

Effective April 1, 2008, MDHHS will no longer pay a unit dose incentive fee.

7.11 Medical Supplies and Prefilled Syringes

Effective for dates of service January 1, 2006, and after, MDHHS no longer covers the following medical supply items and prefilled syringes as a pharmacy benefit. These items are covered only as a medical supplier benefit billed using the appropriate procedures on the ANSI X12N 837P, Version 4010A1, or CMS 1500 format not on the NCPDP Version D.0, Batch 1.2, or Universal Claim format.

- Blood glucose test strips
- Lancets
- Urine glucose/acetone test strips
- Nutritional supplements (e.g., protein replacements and infant formulas)
- Heparin lock flush prefilled syringes
- Normal saline prefilled syringes

Pharmacies desiring to become approved MDHHS medical suppliers must refer to the **General Information for Providers** chapter of the **Michigan Medicaid Provider Manual**.

Magellan Medicaid Administration is not responsible for medical supplier enrollment.

7.12 Partial Fills – Can Only be Used for Inventory Shortages in an LTC Facility

7.12.1 Initial Fill – Online Process

- Enter actual QUANTITY DISPENSED (NCPDP Field # 442-E7)
- Enter actual DAYS SUPPLY (NCPDP Field # 4Ø5-D5)
- Enter DISPENSING STATUS (NCPDP Field # 343-HD) = "P"
- Enter QUANTITY INTENDED TO BE DISPENSED (NCPDP Field # 344-HF) = the total prescribed amount for the prescription
- Enter DAYS SUPPLY INTENDED TO BE DISPENSED (NCPDP Field # 345-HG) = the total days' supply from the prescription

7.12.2 Subsequent Partial Fill – Online Process

- Enter ASSOCIATED PRESCRIPTION/SERVICE REFERENCE # (NCPDP Field
- #456-EN) = the prescription number from the initial partial fill
- Enter ASSOCIATED PRESCRIPTION/SERVICE DATE (NCPDP Field # 457-EP) = the date of service of the most recent partial fill in the series
- Enter actual QUANTITY DISPENSED (NCPDP Field # 442-E7)
- Enter actual DAYS SUPPLY (NCPDP Field # 4Ø5-D5)
- Enter DISPENSING STATUS (NCPDP Field # 343-HD) = "P"
- Enter QUANTITY INTENDED TO BE DISPENSED (NCPDP Field # 344-HF) = the total prescribed amount for the prescription
- Enter DAYS SUPPLY INTENDED TO BE DISPENSED (NCPDP Field # 345-HG) = the total days' supply from the prescription

7.12.3 Completion of Partial Fill – Online Process

- Enter ASSOCIATED PRESCRIPTION/SERVICE REFERENCE # (NCPDP Field # 456-EN) = the prescription number from the initial partial fill
- Enter ASSOCIATED PRESCRIPTION/SERVICE DATE (NCPDP Field # 457-EP) = the date of service of the most recent partial fill in the series
- Enter actual QUANTITY DISPENSED (NCPDP Field # 442-E7)
- Enter actual DAYS SUPPLY (NCPDP Field # 4Ø5-D5)
- Enter DISPENSING STATUS (NCPDP Field # 343-HD) = "C"
- Enter QUANTITY INTENDED TO BE DISPENSED (NCPDP Field # 344-HF) = the total prescribed amount for the prescription

- Enter DAYS SUPPLY INTENDED TO BE DISPENSED (NCPDP Field # 345-HG) = the total days' supply from the prescription

Notes:

- Partial fill functionality cannot be used with Multi-Ingredient Compound claims.
- Partial fills may not be transferred from one pharmacy to another.
- Two partial fill transactions may not be submitted on the same day; the Service Date must be different for each of the partial transactions and the completion transaction.
- Completion fill must be submitted within 60 days of original partial fill.
- NCPDP EN-M/I Associated Prescription/Service Ref Number should be blank unless you are submitting for a partial fill, otherwise please remove any values from this field.

7.12.4 Initial Incremental Fill for CII Drugs

- Enter actual QUANTITY DISPENSED (NCPDP Field # 442-E7)
- Enter actual QUANTITY PRESCRIBED (NCPDP Field # 460-ET)
- Enter 0 (zero) in the FILL NUMBER field (NCPDP Field # 403-D3)

7.12.5 Subsequent Incremental Fill for CII Drugs

- Enter same RX number as Incremental Fill
- Enter QUANTITY DISPENSED (NCPDP Field # 442-E7) this should be less than the incoming QUANTITY PRESCRIBED
- Enter actual QUANTITY PRESCRIBED (NCPDP Field # 460-ET)
- Enter 0 (zero) in the FILL NUMBER field (NCPDP Field # 403-D3

Notes:

- GSN of the incoming Product/Service ID matches the GSN of the Product/Service ID on the historical claim with the same prescription number found in the patient medication history.
- Service Provider ID (NPI) of the incoming claim matches the Service Provider ID (NPI) on the historical claim with the same prescription number found in the patient medication history.
- Historical claim was identified as an Initial Incremental Fill.

7.13 Vaccine Submissions

7.13.1 Seasonal Flu Vaccine

- Michigan Department of Health and Human Services will pay an administrative fee in accordance with the fee schedule found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448_78560---,00.html. All benefit plans are eligible to receive the fee except **any** Emergency Services Only, Managed Care, Spenddown, Incarcerated, and Medicare/Medicaid dual beneficiaries. The following guidelines apply for these claims
- No co-pay will be charged to the patient
- No dispense fee will be paid
- Patients ages 19 and older are eligible to receive the vaccine
- The pharmacy should be instructed to bill the appropriate incentive fee in field (NCPDP Field #438-E3) as determined by the form of the vaccine.
- The pharmacy should be instructed to bill Drug Utilization Review (DUR)/Professional
- Pharmacy Services (PPS) segment with a value of "1" in the DUR/PPS Code Counter
- (NCPDP Field # 473-7E) and a value of MA (medication administered) for the Professional Service Code (NCPDP Field # 440-E5)
- Max ingredient cost is per MDHHS covered products for the season.

7.13.2 Other Vaccines

All vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including seasonal influenza vaccines, administered by pharmacists are covered for adults aged 19 and older. Please refer to the *Medicaid Provider Manual Pharmacy* Chapter, *Section 14.15* for further information regarding administration and reporting requirements.

7.14 Professional Dispensing Fee

Please note that there is a maximum of 13 dispensing fees paid in a rolling 365-day period for same pharmacy and same drug.

7.15 Clinical Trial Attestation Policy

Effective: February 1, 2023 for items and services that require a Prior Authorization and were provided in connection with a beneficiary's participation in a qualified clinical trial:

- A completed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210) is required by Section 210 of the Consolidated Appropriations Act of 2021.
- The completed BPHASA-2210 must be submitted with Pharmacy PA Requests.
- To submit a fee-for-service pharmacy PA request for items furnished in connection with a beneficiary's participation in a qualified clinical trial, visit https://michigan.magellanrx.com >> Provider Portal >> Forms >> Prior Authorization Forms.
- For questions related to Fee for Service pharmacy PA requests, contact Magellan Pharmacy Technical Call Center at 877-624-5204.
- For information related to Medicaid Health Plan pharmacy prior authorization requests, visit www.michigan.gov/MCOpharmacy.

8.0 Coordination of Benefits (COB)

Coordination of benefits is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and prevention of duplicate payments.

Third-party liability (TPL) refers to:

- An insurance plan or carrier;
- A program; and
- A commercial carrier.

The plan or carrier can be:

- An individual;
- A group;
- Employer-related;
- Self-insured; and
- Self-funded plan.

The program can be Medicare, which has liability for all or part of a beneficiary's medical or pharmacy coverage.

The commercial carrier can be automobile insurance and workers' compensation.

The terms "third-party liability" and "other insurance" are used interchangeably to mean any source other than Medicaid that has a financial obligation for health care coverage. Pharmacies should refer to the *Coordination of Benefits* chapter of the *MDHHS Medicaid Provider Manual* for specific requirements.

MDHHS is always the payer of last resort. For beneficiaries who have other insurance coverage, pharmacies must bill the other insurance carriers (including Medicare) before billing MDHHS. Further, pharmacies must investigate and report the existence of other insurance or liability and utilize the other payment sources to their fullest extent prior to filing a claim with MDHHS.

8.1 COB General Instructions

8.1.1 Identifying Other Insurance Coverage

From MDHHS Sources

Other insurance information is not displayed on the beneficiary's "mihealth" card. Pharmacies are responsible for verifying eligibility and other insurance information by using the Community Health Automated Medicaid Processing System (CHAMPS). Refer to *Directory Appendix* in the *Michigan Medicaid Provider Manual for CHAMPS* contact information.

POS Claims

If a beneficiary has other coverage on a date of service and it is not reported on the pharmacy's claim submission, Magellan Medicaid Administration will deny the claim in the POS system and return the following information in the Additional Message field.

- Carrier ID (Refer to the next section for a description)
- Carrier Name
- Beneficiary Policy Number

Carrier ID List

A Master Carrier ID List providing carrier codes, names, and addresses is available on the MDHHS website. The Magellan Medicaid Administration website at https://michigan.magellanrx.com/ provides a quick link to this file. Select the link to Links and then Michigan Department of Health and Human Services. If a beneficiary has other insurance and that carrier is not identified on the MDHHS Carrier ID Listing, pharmacies may enter "99999999" in the Other Payer ID.

Other Insurance Discrepancies on MDHHS Files

Pharmacies should report any changes or newly identified commercial insurance by accessing www.michigan.gov/ReportTPL and submitting the online form. If a pharmacy has an urgent access to care issue, please call 1-800-292-2550 to report changes to other insurance. Urgent requests are normally resolved within 24 hours.

Beneficiaries may be instructed to notify the MDHHS Beneficiary Help Line available at 1 -800-624-3195.

The MDHHS Third-Party Liability (TPL) staff is required to validate the accuracy of other insurance changes prior to updating the system. Please note that MDHHS TPL staff are only available Monday–Friday, 8:00 a.m. – 5:00 p.m. Changes are transmitted to the MDHHS PBM, Magellan Medicaid Administration, multiple times a day.

8.1.2 Third-Party Liability Processing Grid

Pharmacies must comply with the instructions in the Third-Party Liability (TPL).

Processing Grid for appropriate Other Coverage Code values to report in the Claim Segment. The TPL Processing Grid is available at https://michigan.magellanrx.com/. Select the link to Providers, Other Notices, and then Pharmacy Claims Submission. The following table (Table 9 – Other Coverage Code) summarizes values for the Other Coverage Code.

Table 9 – Other Coverage Code

Code	Descriptions	Comments
1	No Other Coverage	No longer supported. This value will result in payment denial with NCPDP Reject Code 13, Missing/Invalid Other Coverage Code, which cannot be overridden.
2	Other Coverage Exists – Payment Collected	When this value is used, the pharmacy must report the other insurance payment collected and bill MDHHS only for the beneficiary's liability. Payment will not exceed MDHHS allowed amounts.
3	Other Coverage Exists – This Claim Not Covered	This value will pay when a drug is not covered by the beneficiary's other insurance but is covered by MDHHS and a valid Other Payer Reject Code (NCPDP Field # 4726E) is submitted. Claims not meeting this requirement will be denied with NCPDP Reject Code 6E, Missing/Invalid Other Payer Code.
4	Other Coverage Exists – Payment Not Collected	This value must be used only when a beneficiary has not met the other insurer's deductible or the drug cost is less than the beneficiary's other insurer's co-pay. Payment will not exceed MDHHS allowed amounts.
5	Managed Care Plan Denial	No longer supported. These values will result in payment denial with NCPDP Reject Code 13, Missing/Invalid Other Coverage Code, which cannot be overridden.
6	Other Coverage Denied – Not a Participating Provider	
7	Other Coverage Exists – Not in Effect on DOS	
8	Claim is billing for co-payment.	

8.1.3 Magellan Medicaid Administration's COB Processing

If a beneficiary has other coverage on the date of service and other payments amounts were not listed on the claim, Magellan Medicaid Administration will deny payment with NCPDP Error Code 41, Submit Bill to Other Processor or Primary Payer The following information in the Additional Message field:

- Carrier ID (the MDHHS unique eight-digit code identifying the other insurer)
- Carrier Name
- Beneficiary Policy Number

New 07/01/2007 – Pharmacy Level TPL Override

Pharmacies can now submit a pharmacy level override using Prior Authorization Type Code (Field # 461-EU) = "1" to override the NCPDP 70 – NDC Not Covered with additional transaction message, "TPL amount collected must be greater than $2.00" instead of calling or faxing the Magellan Medicaid Administration support center.

If other insurance is indicated on the MDHHS eligibility file, Magellan Medicaid Administration will process the claim as TPL, regardless of what TPL codes the pharmacy submits. Also, if no other insurance is indicated on the MDHHS eligibility file but the pharmacy submits TPL data, Magellan Medicaid Administration will process the claim using the other payment amounts.

Note: If payment is received from multiple other carriers, Magellan Medicaid Administration requires pharmacies to enter the amount paid from all valid carriers in the repeating Other Payer fields.

Reporting Patient Responsibility Amounts (New with D.0 – Replaces Former 20.9 Scenario)

Effective for claims submitted using NCPDP D.0, claims submitted with Other Coverage Code 2 or 4 must report the primary insurance co-pay responsibility in the Other Payer Patient Responsibility Amount (NCPDP Field # 352-NQ).

Billing Instructions

When submitting OCC (NCPDP Field # 3Ø8-C8) with a value equal to "2" in the Claim Segment for a COB claim when the primary insurer made a payment, report the following information:

- Report the amount of any beneficiary liability (co-payment, coinsurance, and/or deductible) in the Other Payer Patient Responsibility Amount (NCPDP Field # 352NQ) in the COB Segment.
- Report a zero-dollar ($0.00) amount if there is no beneficiary liability under the primary insurer in the Other Payer Patient Responsibility Amount (NCPDP Field # 352-NQ) in the COB Segment.
- If the Other Payer Patient Responsibility Amount is not populated, the claim will reject with NCPDP reject code. NQ – M/I Other Payer-Patient Responsibility Amount.
- An override will not be granted.
- Report the amount paid by primary insurer in the Other Payer Amount Paid field (NCPDP Field # 431-DV).

8.1.4 The MDHHS Pharmaceutical Product List (MPPL) and COB

Before MDHHS payment will be made for claims with other insurance liabilities, all requirements listed in the MPPL must be met. This includes prior authorization requirements.

8.1.5 Discount Card/Discount Benefit Response from Primary Insurance - Medicaid COB Requirements

When a pharmacy bills a primary insurance and receives a discount card/discount benefit response, the pharmacy should reverse the claim and resubmit with value of '8' (Patient also eligible with federal/state funded program, coordination of benefit restrictions apply) in the Eligibility Clarification Code Field (NCPDP Field # 309-C9) to receive an appropriate plan benefit response for submission to Medicaid as secondary.

Using an Eligibility Clarification Code of 8 will prevent the claim from reprocessing under the primary insurers plan-sponsored drug discount program, and instead return the expected plan benefit rejected response with the appropriate reject code(s), or paid response with the expected plan benefit pricing. This ensures that claims submitted to Medicaid, or other MDHHS pharmacy programs billed either secondary or tertiary for Coordination of Benefits (COB) will continue processing successfully in accordance with established requirements and also prevents the pharmacy from being charged discount card administrative fees in error.

8.2 Special Instructions for Medicare Part B and Part D

Pharmacies must bill Medicare prior to billing MDHHS for a beneficiary's prescription costs. Part B is medical insurance for doctor services, outpatient hospital care, durable medical equipment (DME), and some take-home drugs. Part D is the Medicare prescription drug program that was implemented January 1, 2006. As explained in the next sections, there are unique COB considerations for Medicare Parts B and D.

8.2.1 Identifying Individuals Enrolled in Medicare

MDHHS uses its own eight-digit Carrier IDs (Table 10 – MDHHS Carrier IDs Identifying Medicare) to identify beneficiaries eligible or enrolled in Medicare.

Table 10 – MDHHS Carrier IDs Identifying Medicare

Other Payer Carrier ID	Description	Comments
11111111	Medicare – Eligible for, but not enrolled	Applies to both Part B and D.
12121212	Medicare – Eligible for, but not confirmed by CMS	Applies to both Part B and D. If the beneficiary is less than 65 years old and after confirming the beneficiary is not Medicare eligible, the pharmacy may call the Magellan Medicaid Administration Pharmacy Support Center for an override detailing how they verified the patient is not eligible for Medicare Part D
33333333	Medicare – Eligible in Part A	
22222222	Medicare – Eligible, but **Opted Out** of Medicare Part D	
66666666	Medicare – Enrolled in Medicare Part D	
44444444	Medicare – Enrolled in Part B	
55555555	Medicare – Enrolled in Medicare Advantage Plan (Medicare Part C)	
77777777	Medicare – Aliens, but not enrolled	

8.2.2 Medicare Part B

Appendix D – Medicare Part B Covered Drugs of this manual lists examples of drugs commonly covered by Medicare Part B. For these and other drugs covered by Medicare Part B, pharmacies must first bill Medicare prior to billing MDHHS. After the payment is received from Medicare Part B, MDHHS may pay the co-pays/coinsurance/deductible up to the MDHHS allowable reimbursement levels and if pharmacies:

- Obtain override from the Magellan Medicaid Administration Clinical Support Center for payment of the Part B coinsurance. If claims are denied for payment by Medicare or Medicare Part B does not pay 80 percent, the pharmacy must submit appropriate documentation (e.g., explanation of benefits or remittance advices) from Medicare prior to being granted an override for payment by the Clinical Support Center.
- Bill with Other Coverage Code "2" in the Claim Segment, after obtaining the Clinical Support Center's authorization.

When pharmacies do not reflect Medicare Part B payments, their billings will deny with:

- NCPDP Error Code 41, Submit claim to other processor or primary payer; and
- An Additional Message, Bill Medicare Part B.

8.2.3 Medicare Part D

Effective for dates of service on January 1, 2013, and after, beneficiaries dually eligible/enrolled in Medicare and Medicaid (the dual eligibles) receive most prescription drug coverage from Part D. Further, MDHHS will not reimburse Part D prescription drug co-pays, coinsurance, or deductibles for beneficiaries who are eligible for or enrolled in Part D. For additional information about Medicare Part D plans, pharmacies may visit the CMS website at https://www.cms.gov/Medicare/Medicare.html or call 1-800-MEDICARE or call 1-866-835-7595, which is the CMS-dedicated pharmacy help line.

For dual eligibles, MDHHS continues to pay (1) for Part B co-pays/deductibles/coinsurance (as previously described) and (2) for the following Part D excluded drug classes as stipulated in the Michigan Pharmaceutical Product List (MPPL) and listed on the Medicare Dual Eligible Covered NDC List found at https://michigan.magellanrx.com/ Provider > Documents > Fee For Service Drug Coverage > Medicare Dual Eligible Covered NDC List.

- Specific Over-the-Counter (OTC) drugs
- Specific Prescription Vitamins/Minerals
- Smoking Cessation Products

All MDHHS coverage edits and utilization controls remain in place for the Part B copays/coinsurance/deductibles payments and for the Part D excluded drug classes. Other claims submitted for dual eligibles will deny with the following information.

- NCPDP Error Code 41, Submit Bill to Other Processor or Primary Payer.
- For the dual eligibles, NCPDP Error Code 41 cannot be overridden. Coordination of benefits (COB) overrides are not allowed for Part D covered drugs.
- Part D plan information in the Additional Message field:
  - Medicare Contract/Plan ID

- Plan Name
- Plan Phone Number

If a patient is eligible for Medicare Part D but has not enrolled in a Part D plan, please refer to the Li-NET link https://www.humana.com/pharmacy/pharmacists/ for claims processing instructions. The Limited Income NET Program (or LI NET) is designed to eliminate any gaps in coverage for low-income individuals transitioning to Medicare Part D drug coverage.

9.0 Prescriber Enrollment Requirement

Effective October 1, 2019, providers who prescribe drugs to Medicaid beneficiaries must actively be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS), the state's online Medicaid enrollment system. The Michigan Department of Health and Human Services (MDHHS) will prohibit Fee-for-Service (FFS) and Medicaid Health Plan (MHP) payment for prescription drug claims written by a prescriber who is not enrolled in CHAMPS. Claims will be denied for NCPDP EC 889 – Prescriber Not Enrolled in State Medicaid Program. This is required under federal law. For more information on this, you may direct prescribers to the following resources:

- MDHHS Provider Enrollment website: https://www.michigan.gov/medicaidproviders
- MDHHS Provider Enrollment Help Desk: (800) 292-2550
- MDHHS Mailbox: MDHHSPharmacyServies@michigan.gov

9.1 Submission Clarification Codes

Since July 1, 2018, Medicaid Fee-for-Service (FFS) and Medicaid Health Plans have posted the following informational edit on pharmacy claims for drugs written by a prescriber who is not enrolled in CHAMPS:

- NCPDP Code 889: PRESCRIBER NOT ENROLLED IN STATE MEDICAID PROGRAM

Starting October 1, 2019, subsequent claims with this edit will be denied.

There may be certain emergency circumstances in which a beneficiary must receive their prescription medication. In those instances, the pharmacy may override the edit using either of the following Submission Clarification Codes in NCPDP field 420-DK when applicable:

- 13 – Payer-Recognized Emergency/Disaster Assistance Request
- 55 – Prescriber Enrollment in State Medicaid Program has been validated

When the above codes are not applicable, a pharmacy or prescriber may initiate an override request by contacting the healthcare payer's Pharmacy Help Desk. For overrides on Medicaid FFS claims, call 877-624-5204. For Medicaid Health Plan contact information, visit www.michigan.gov/MCOpharmacy.

10.0 Brand versus Generic Requirements

- To override generic pricing, a clinical prior authorization for "Brand Medically Necessary" (DAW 1) is required.
- The beneficiary is never required to pay a MAC penalty (difference between the brand and the generic product).
- Requests to override PA – Brand Medically Necessary (DAW 1) will be handled by the Magellan Medicaid Administration Clinical Support Center.
- If the drug is a multi-source brand (MSB) and a MAC exists and the claim is submitted with a DAW 1 – Substitution Not Allowed by Prescriber, the claim will deny unless a clinical prior authorization is on file for the beneficiary (except for exceptions).
- If a prior authorization is on file for the beneficiary, the claim submitted with a DAW 1 will reimburse using the standard reimbursement logic.
- If a prior authorization is on file for the beneficiary and the claim is not submitted with a DAW 1, the claim will be reimbursed using the standard reimbursement logic, including the MAC price.
- Overrides for DAW 1 will allow the MAC and NADAC-generic pricing to be bypassed and the claim will pay at NADAC-brand.
- DAW 2 is not allowed.
- Allow submission of DAW-9 (Substitution Allowed by Prescriber but Plan Requests Brand) on the preferred brand claims

11.0 COVID-19

11.1 Waiving COVID-19 Related Prescription Co-pays

MDHHS is waiving co-pays for beneficiaries at point-of-sale for drug products to treat COVID-19. Both Fee-for-Service (FFS) and managed care pharmacy claims using the National Council for Prescription Drug Programs (NCPDP) claim format should be submitted using one of the options below. This will ensure that prescriptions for the treatment of COVID-19 will not be subject to co-pays at point-of-sale or during post-adjudication cost share invoicing processing for a patient diagnosed with COVID-19.

- Diagnosis Code: Pharmacy claims should be submitted with ICD-10-CM code B97.29, U07.1, Z11.52 or Z20.822 when diagnosis code is reported on the prescription order.
- Prior Authorization Type Code: In instances where the prescription does not include a COVID-19 diagnosis code and the pharmacy understands the prescription is for the treatment of COVID-19, the pharmacy shall submit the Prior Authorization Type Code value of "4" (4 = Exemption from Co-pay and/or Co-insurance) in NCPDP Field 461-EU. Pharmacies that are unable to submit these indicators should contact the Magellan Pharmacy Technical Call Center at 877-624-5204 for a co-pay override.
- Help Desk Override Request: For overrides on FFS claims, call the Magellan Pharmacy Technical Call Center at 877-624-5204. For Medicaid Health Plan contact information, visit www.michigan.gov/MCOpharmacy.
- Pharmacies who have submitted claims for COVID-19 treatment should refund co-pay amounts to the beneficiary. Pharmacies must resubmit claims to receive the full amount.

11.2 COVID-19 Vaccine Claim Processing

Effective 12/01/2020, Providers may submit claims for the COVID-19 vaccine. NCPDP recommends specific values for COVID-19 claims:

- SUBMISSION CLARIFICATION CODE (NCPDP Field # 42Ø-DK) = 2 (Other Override OR = 6 (Starter Dose)
- PROFESSIONAL SERVICE CODE (NCPDP Field # 44Ø-E5) = Value “MA” (Medication Administered). Claims will deny if MA is not entered on the claim.
- INCENTIVE AMOUNT SUBMITTED (NCPDP Field # 438-E3). Incentive fee will be paid where submission clarification code = 2 (initial dose) is submitted on the claim. Incentive fee will be paid where submission clarification code = 6 (subsequent dose) is submitted on the claim.
- PRESCRIPITION ORIGIN CODE (NCPDP Field # 419-DJ) = Value 5 (Pharmacy)

- BASIS OF COST DETERMINATION (NCDPD Field # 423-DN) = Value 15 (free product or no associated cost)
- DAYS SUPPLY (NCPDP Field # 405-D5 = Value 1
- FILL NUMBER (NCPDP Field # 403-D3) Values are as follows:
  - 0
  - 1 – 99
- PRESCRIPTION/SERVICE REFERENCE NUMBER (NCPDP Field # 4Ø2-D2)
- PATIENT RESIDENCE (NCPDP Field # 384-3X) values are as follows:
  - 0 – Not Specified
  - 1 – Home
  - 2 – Skilled Nursing Facility PART B ONLY
  - 3 – Nursing Facility
  - 4 – Assisted Living Facility
  - 5 – Custodial Care Facility PART B ONLY
  - 6 – Group Home
  - 7 – Inpatient Psychiatric Facility
  - 8 – Psychiatric Facility-Partial Hospitalization
  - 9 – Intermediate Care Facility/Mentally Retarded
  - 10 – Residential Substance Abuse Treatment Facility
  - 11 – Hospice
  - 12 – Psychiatric Residential Treatment Facility
  - 13 – Comprehensive Inpatient Rehabilitation Facility
  - 14 – Homeless Shelter
  - 15 – Correctional Institution
- PHARMACY SERVICE TYPE (NCPDP Field # 147-U7) values are as follows:
  - 1 – Community/Retail Pharmacy Services
  - 2 – Compounding Pharmacy Services
  - 3 – Home Infusion Therapy Provider Services
  - 4 – Institutional Pharmacy Services
  - 5 – Long Term Care Pharmacy Services
  - 6 – Mail Order Pharmacy Services
  - 7 – Managed Care Organization Pharmacy Services
  - 8 – Specialty Care Pharmacy Services
  - 99 – Other
- PLACE OF SERVICE (NCPDP Field # 307-C7)

11.2.1 COVID-19 Vaccine Reimbursement Logic

The following reimbursement logic will be in place for COVID 19 vaccine claims:

1. Pharmacies may bill and will be reimbursed for the COVID-19 vaccine administration in accordance with existing policies and reimbursement rates that align with the practitioner fee screens.
2. Reimbursement logic will pay $0.00 dispense fee; reimbursement will occur through incentive fees.
3. Incentive fee logic will pay $42.00.
4. Member co-pays are waived.
5. Claims for the ESO groups will need to be submitted with a Level of Service = 3 in order to pay. LEVEL OF SERVICE (NCPDP Field #418DI) Claims for the ESO Groups will need to be submitted with a Level of Service = 3 in order for the claim to pay.

11.3 COVID-19 Vaccine Pharmacy Billing for Additional Doses and Place of Residence Administration

Effective August 12, 2021, the Michigan Department of Health and Human Services (MDHHS) is covering additional doses of the Pfizer-BioNTech COVID-19 vaccine and the Moderna COVID-19 vaccine in alignment with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations.

Effective June 8, 2021, COVID-19 vaccine administration is covered for Medicaid recipients in their place of residence. Pharmacies may bill and will be reimbursed for the COVID-19 vaccine administration in accordance with existing policies and reimbursement rates that align with the practitioner fee screens. Pharmacy specific COVID-19 vaccine services billing instructions will be incorporated into the Pharmacy Claims Processing Manual at: >> Documents >> Manuals.

Pharmacies must submit claims in accordance with NCPDP Guidance as follows below:

- Professional Service Code = "MA" (Medication Administered)
- Incentive Amount Submitted
- Submission Clarification Code (SCC) '2' (Other Override) and '6' (Starter Dose)
  - SCC = 2 indicates a first dose
  - SCC = 6 indicates a final dose
  - **SCC = 7 indicates additional dose**
- Prescription Origin Code '5'

- Basis of Cost Determination '15' (free product or no associated cost)
- **FOR HOME ADMINISTRATION: Place of Service = "12" (Home)**

For more information on billing for COVID-19 Vaccine administration, please review the NCPDP Guidance.

MDHHS will reimburse a $42.00 incentive fee regardless of first, second or single dose. An additional $37.28 will be reimbursed for administration in the home (i.e., Place of Service = 12). There is no co-pay required for members to receive the vaccine.

COVID-19 vaccine services are covered for beneficiaries with the ESO benefit plan. Services are covered consistent with treatment provisions outlined in MSA 20-40 and claims for the ESO groups will need to be submitted with a Level of Service = 3.

11.4 COVID-19 Home Tests

The Michigan Department of Health and Human Services (MDHHS) is expanding coverage of select molecular and antigen home tests that have been dispensed by a Medicaid-enrolled participating pharmacy for date of service on and after August 30, 2021 as outlined in MSA 21-50.

Home tests FDA-authorized or approved for the detection of COVID-19 will be approved for pharmacy benefit coverage. Medicaid will cover the following home tests up to a maximum of one per day.

Test Description
Infectious agent antigen detection by immunoassay, severe acute respiratory
Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2

Subject to change, a list of Medicaid-covered National Drug Codes (NDCs) applicable to the above tests is available. These home tests will reimburse at point-of-sale in accordance with existing Medicaid pharmacy policies. Reimbursement is the lesser of the pharmacy's usual and customary (U&C) charge or the MDHHS product cost payment limits. MDHHS' product cost payment limits are based on the NDC the pharmacy identifies as the product that was dispensed. If a covered NDC does not have an associated price, MDHHS will reimburse U&C up to the MDHHS Maximum Allowed Cost (MAC). Pharmacies should refer to the Pharmacy chapter of the MDHHS Medicaid Provider Manual for complete information regarding Medicaid pharmacy policies.

National Council of Prescription Drug Programs (NCPDP) Billing

- Pharmacies must coordinate benefits by billing other insurances, including Medicare, before billing Medicaid in accordance with Bulletin Pharmacy 01-03.

- Submission of the NPI: When a pharmacist is the ordering provider of a test, their individual Type 1 NPI should be reported in the Prescriber ID (411-DB) field with Submission Clarification Code (SCC) (420-DK): 13 (Payer Recognized Emergency/Disaster Assistance Request).

Cost Sharing Exemption

COVID-19 laboratory services will continue to be covered without co-payment. This includes COVID-19 home testing kits dispensed by a Medicaid-enrolled pharmacy. Providers should not collect pharmaceutical co-pays for COVID-19 home testing kits.

Appendix A – Payer Specifications for NCPDP D.0

Michigan Medicaid D.0 Payer Specification

August 30, 2021

Request Claim Billing/Claim Re-Bill Payer Sheet

****Start of Request Claim Billing/Claim Re-bill (B1/B3) Payer Sheet Template****

General Information

Request Claim Billing/Claim Re-Bill Payer Sheet

****Start of Request Claim Billing/Claim Re-Bill (B1/B3) Payer Sheet****

General Information

Payer Name: Michigan Medicaid		
Plan Name/Group Name: MI01/MIMEDICAID	**BIN**:009737	**PCN**: P008009737
Processor: Processor/Fiscal Intermediary		
Effective as of: 01/01/2012	**NCPDP Telecommunication Standard Version/Release #**: D.0	
NCPDP Data Dictionary Version Date: 10/2017	**NCPDP External Code List Version Date**: 10/2017	
Contact/Information Source: https://michigan.magellanrx.com/		
Certification Testing Window: TBD		
Certification Contact Information: 804-217-7900		
Provider Relations Help Desk Info: 866-254-1669		
Other versions supported: VERSION 5.1 UNTIL 01/01/2012 " SUBJECT TO CHANGE*		

Other Transactions Supported

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

Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal
B3	Claim Re-bill
E1	Eligibility Verification

Field Legend for Columns

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

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

Claim Billing/Claim Re-bill Transaction

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

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

Transaction Header Segment		Claim Billing/Claim Re-bill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN NUMBER	009737	M	Michigan Department of Community Health
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	

Transaction Header Segment		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø3-A3	TRANSACTION CODE	B1 B2 B3 E1	M	B1 Billing B2 Reversal B3 Re-Bill E1 Eligibility Verification
1Ø4-A4	PROCESSOR CONTROL NUMBER	P008009737	M	
1Ø9-A9	Transaction Count	1 One Occurrence 2 Two Occurrences 3 Three Occurrences 4 Four Occurrences	M	Specify max number of transactions supported for each transaction code.
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 - National Provider Identifier (NPI)	M	
2Ø1-B1	SERVICE PROVIDER ID	NPI	M	
4Ø1-D1	DATE OF SERVICE	Format = CCYYMMDD	M	
11Ø-AK	SOFTWARE VENDOR/ CERTIFICATION ID		M	Assigned by Magellan Medicaid Administration

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

Insurance Segment Identification (111-AM) = "Ø4"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
3Ø2-C2	CARDHOLDER ID		M	Medicaid ID Number <Michigan Medicaid> 10-digit ID
3Ø1-C1	GROUP ID	MIMEDICAID	R	
3Ø3-C3	PERSON CODE			*Imp Guide:* Required if needed to uniquely identify the family members within the Cardholder ID. *Payer Requirement:* Same as *Imp Guide*.

Insurance Segment Identification (111-AM) = "Ø4"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
3Ø6-C6	PATIENT RELATIONSHIP CODE	1 = Cardholder	R	
36Ø-2B	MEDICAID INDICATOR	Two-character State Postal Code indicating the state where Medicaid coverage exists.	RW	*Imp Guide*: Required, if known, when patient has Medicaid coverage. Ex: MI
115-N5	MEDICAID ID NUMBER	A unique member identification number assigned by the Medicaid Agency	RW	*Imp Guide*: Required, if known, when patient has Medicaid coverage.

Patient Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required for B1 and B3 transactions

Patient Segment Segment Identification (111-AM) = "Ø1"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
331-CX	PATIENT ID QUALIFIER	Ø1 = Social Security Number 1J = Facility ID Number Ø2 = Driver's License Number Ø3 = US Military ID Ø4 = Non-SSN-based patient identifier assigned by health plan Ø5 = SSN-based patient identifier assigned by health plan Ø6 = Medicaid ID Ø7 = State Issued ID Ø8 = Passport ID Ø9 = Medicare HIC# 1Ø = Employer Assigned ID 11 = Payer/PBM Assigned ID 12 = Alien Number 13 = Government Student VISA Number 14 = Indian Tribal ID 99 = Other	RW	*Imp Guide*: Required if Patient ID (332-CY) is used. EA = Medical Record Identification Number (EHR) *Payer Requirement*: Same as *Imp Guide*.
332-CY	PATIENT ID		RW	*Imp Guide*: Required if necessary for state/federal/regulatory agency programs to validate dual eligibility. *Payer Requirement*: Same as *Imp Guide*.
31Ø-CA	PATIENT FIRST NAME		R	*Imp Guide*: Required when the patient has a first name.
311-CB	PATIENT LAST NAME		R	*Imp Guide*: Required when the patient has a last name.

Patient Segment Segment Identification (111-AM) = "Ø1"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
3Ø7-C7	PLACE OF SERVICE		RW	*Imp Guide*: Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Same as *Imp Guide*. FORMERLY PATIENT LOCATION NCPDP recommends specific values for COVID-19 Vaccine claims: For COVID 19 Vaccine: Home Administration = 12 (Home)
384-4X	PATIENT RESIDENCE	Ø = Not Specified 1 = Home 2 = Skilled Nursing Facility. PART B ONLY 3 = Nursing Facility 4 = Assisted Living Facility 5 = Custodial Care Facility. PART B ONLY 6 = Group Home 7 = Inpatient Psychiatric Facility 8 = Psychiatric Facility – Partial Hospitalization 9 = Intermediate Care Facility/ Mentally Retarded 1Ø = Residential Substance Abuse Treatment Facility 11 = Hospice 12 = Psychiatric Residential Treatment Facility 13 = Comprehensive Inpatient Rehabilitation Facility 14 = Homeless Shelter 15 = Correctional Institution	RW	*Imp Guide*: Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Same as *Imp Guide*.

Claim Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent	X	
This payer supports partial fills	X	
This payer does not support partial fills		

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide*: For Transaction Code of "B1," in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1"
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	Blank ØØ = Not specified (Must be submitted for compound claims) Ø3 = National Drug Code (NDC)
4Ø7-D7	PRODUCT/SERVICE ID	NDC for non-compound claims '0' for compound claims	M	
456-EN	ASSOCIATED PRESCRIPTION/ SERVICE REFERENCE NUMBER		RW	*Imp Guide*: 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. *Payer Requirement*: Same as *Imp Guide*.

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
457-EP	ASSOCIATED PRESCRIPTION/ SERVICE DATE		RW	*Imp Guide*: Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if Associated Prescription/Service Reference Number (456-EN) is used. Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. *Payer Requirement*: Same as *Imp Guide*.
442-E7	QUANTITY DISPENSED	Metric Decimal Quantity	R	
460-ET	QUANTITY PRESCRIBED		RW	*Imp Guide:* Required when a transmission is for a Scheduled II drug as defined in 21 CFR 1308.12 and per CMS 0055-F (Compliance Date 09/21/2020). Refer to the *D.0 Editorial Document*
4Ø3-D3	FILL NUMBER	Ø = Original dispensing 1-99 = Refill number – Number of the replenishment	R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	1 = Not a Compound 2 = Compound	R	

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Ø = No Product Selection Indicated 1 = Substitution Not Allowed by Prescriber 2 = Substitution Allowed Patient Requested Product Dispensed 3 = Substitution Allowed-Pharmacist Selected Product Dispensed 4 = Substitution Allowed-Generic Drug Not in Stock 5 = Substitution Allowed-Brand Drug Dispensed as a Generic 6 = Override 7 = Substitution Not Allowed Brand Drug Mandated by Law 8 = Substitution Allowed Generic Drug Not Available in Marketplace 9 = Substitution Allowed by Prescriber but Plan Requests Brand – Patient's Plan Requested Brand Product to Be Dispensed	R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED	Ø = No refills authorized 1–99 = Authorized Refill number - with 99 being as needed, refills unlimited	M	*Imp Guide*: Required if necessary for plan benefit administration. *Payer Requirement*: Same as *Imp Guide*.

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
419-DJ	PRESCRIPTION ORIGIN CODE	Ø = Not Known 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile 5 = Pharmacy	R	*Imp Guide*: Required if necessary for plan benefit administration. *Payer Requirement*: 'Ø' is only used for condoms when there is not a prescription. Required for claims processing. NCPDP recommends specific values for COVID-19 Vaccine claims: Prescription Origin Code = 5 (Pharmacy)
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	*Imp Guide*: Required if Submission Clarification Code (V) is used. *Payer Requirement*: Same as Imp Guide.
42Ø-DK	SUBMISSION CLARIFICATION CODE	1 = No Override 2 = Other Override 3 = Vacation Supply 4 = Lost Prescription 5 = Therapy Change 6 = Starter Dose 7 = Medically Necessary 8 = Process Compound for Approved Ingredients 9 = Encounters 1Ø = Meets Plan Limitations 11 = Certification on File 12 = DME Replacement Indicator 13 = Payer-Recognized Emergency/Disaster Assistance Request 14 = Long Term Care	RW	*Imp Guide*: Required if clarification is needed and value submitted is greater than zero (Ø). *Payer Requirement*: Same as *Imp Guide*. NCPDP recommends specific values for COVID-19 vaccine claims: Incentive Fee will be paid where Submission Clarification Code = 2 (first dose) is submitted on the claim. Incentive Fee will be paid where Submission Clarification Code = 6 (final dose) is submitted on the claim. Incentive Fee will be paid where Submission

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		Leave of Absence 15 = Long Term Care Replacement Medication 16 = Long Term Care Emergency box (kit) or automated dispensing machine 17 = Long Term Care Emergency supply remainder 18 = Long Term Care Patient Admit/Readmit Indicator 19 = Split Billing 20 = 340B 55 = Prescriber Enrollment in State Medicaid Program has been validated 99 = Other		Clarification Code= 7 additional dose
3Ø8-C8	OTHER COVERAGE CODE	Ø = Not Specified by patient 2 = Other coverage exists – payment collected 3 = Other Coverage Billed – claim not covered 4 = Other coverage exists – payment not collected	R	*Imp Guide*: Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers. Required for Coordination of Benefits. *Payer Requirement*: Same as *Imp Guide*.
429-DT	SPECIAL PACKAGING INDICATOR	Ø = Not Specified 1 = Not Unit Dose 2 = Manufacturer Unit Dose 3 = Pharmacy Unit Dose 4 = Custom Packaging 5 = Multi-drug compliance packaging	RW	*Imp Guide*: Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Same as *Imp Guide*.

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
6ØØ-28	UNIT OF MEASURE	EA = Each GM = Grams ML = Milliliters	R	*Imp Guide*: Required if necessary for state/federal/regulatory agency programs. *Payer Requirement*: Required for claim submission.
418-DI	LEVEL OF SERVICE	Ø = Not Specified 1 = Patient consultation 2 = Home delivery 3 = Emergency 4 = 24-hour service 5 = Patient consultation regarding generic product selection 6 = In-Home Service	RW	*Imp Guide*: Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Same as *Imp Guide*.
461-EU	PRIOR AUTHORIZATION TYPE CODE	Ø = Not Specified 1 = Prior Authorization 2 = Medical Certification 3 = EPSDT (Early Periodic Screening Diagnosis Treatment 4 = Exemption from Co-pay and/or Co-insurance 5 = Exemption from Rx 6 = Family Planning Indicator 7 = TANF (Temporary Assistance for Needy Families) 8 = Payer Defined Exemption 9 = Emergency Preparedness	RW	*Imp Guide*: Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Same as *Imp Guide*.

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Same as *Imp Guide*.
343-HD	DISPENSING STATUS	Blank = Not Specified P = Partial Fill C = Completion of Partial Fill	RW	*Imp Guide*: Required for the partial fill or the completion fill of a prescription. *Payer Requirement:* Same as *Imp Guide*.
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	*Imp Guide*: Required for the partial fill or the completion fill of a prescription. *Payer Requirement*: Same as *Imp Guide*.
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	*Imp Guide*: Required for the partial fill or the completion fill of a prescription. *Payer Requirement*: Same as *Imp Guide*.
357-NV	DELAY REASON CODE	1 = Proof of eligibility unknown or unavailable 2 = Litigation 3 = Authorization delays 4 = Delay in certifying provider 5 = Delay in supplying billing forms 6 = Delay in delivery of custom-made appliances 7 = Third party processing delay 8 = Delay in eligibility determination 9 = Original claims rejected or denied due		*Imp Guide*: Required when needed to specify the reason that submission of the transaction has been delayed. *Payer Requirement*: Same as *Imp Guide*.

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		to a reason unrelated to the billing limitation rules 1Ø = Administration delay in the prior approval process 11 = Other 12 = Received late with no exceptions 13 = Substantial damage by fire, etc. to provider records 14= Theft, sabotage/other willful acts by employee		
995-E2	ROUTE OF ADMINISTRATION		RW	*Imp Guide*: Required if specified in trading partner agreement. *Payer Requirement*: Required when submitting compound claims.
996-G1	COMPOUND TYPE	Ø1 = Anti-infective Ø2 = Ionotropic Ø3 = Chemotherapy Ø4 = Pain management Ø5 = TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition Ø6 = Hydration Ø7 = Ophthalmic 99 = Other	RW	*Imp Guide*: Required if specified in trading partner agreement. *Payer Requirement*: Same as Imp Guide.
147-U7	PHARMACY SERVICE TYPE	1 = Community/Retail Pharmacy Services 2 = Compounding Pharmacy Services 3 = Home Infusion Therapy Provider Services	RW	*Imp Guide*: Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer.

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		4 = Institutional Pharmacy Services 5 = Long Term Care Pharmacy Services 6 = Mail Order Pharmacy Services 7 = Managed Care Organization Pharmacy Services 8 = Specialty Care Pharmacy Services 99 = Other		*Payer Requirement*: Same as *Imp Guide*.

Pricing Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent	X	

Pricing Segment Segment Identification (111-AM) = "11"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		RW	*Imp Guide*: Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement*: Same as *Imp Guide*.
433-DX	PATIENT PAID AMOUNT SUBMITTED		RW	*Imp Guide*: Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Same as *Imp Guide*.

Pricing Segment Segment Identification (111-AM) = "11"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement*: Same as *Imp Guide*. NCPDP recommends specific values for COVID-19 vaccine claims: Incentive Fee will be paid where Submission Clarification Code = 2 (initial dose) is submitted on the claim. Incentive Fee will be paid where Submission Clarification Code = 6 (subsequent dose) is submitted on the claim. *Payer Requirement:* Same as *Imp Guide.*
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW***	*Imp Guide*: Required if Other Amount Claimed Submitted Qualifier (479-H8) is used. *Payer Requirement*: Same as *Imp Guide*.
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	Ø1 = Delivery Cost Ø2 = Shipping Cost Ø3 = Postage Cost Ø4 = Administrative Cost Ø9 = Compound Preparation Cost Submitted 99 = Other	RW***	*Imp Guide*: Required if Other Amount Claimed Submitted (48Ø-H9) is used. *Payer Requirement*: Same as *Imp Guide*.

Pricing Segment Segment Identification (111-AM) = "11"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW***	*Imp Guide*: Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement*: Same as *Imp Guide*.
426-DQ	USUAL AND CUSTOMARY CHARGE		R	*Imp Guide*: Required if needed per trading partner agreement. *Payer Requirement*: Required for claim submission.
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION	ØØ = Default Ø1 = AWP Ø2 = Local Wholesaler Ø3 = Direct Ø4 = EAC (Estimated Acquisition Cost) Ø5 = Acquisition Ø6 = MAC (Maximum Allowable Cost) Ø7 = Usual & Customary Ø8 = 34ØB/ Disproportionate Share Pricing Ø9 = Other 1Ø = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost) 13 = Special Patient Pricing 15= Free product or no associated cost	RW	*Imp Guide*: Required if needed for receiver claim/encounter adjudication. *Payer Requirement*: Same as *Imp Guide*. NCPDP recommends specific values for COVID-19 vaccine claims: Basis of Cost Determination '15' (free product or no associated cost)

Prescriber Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Prescriber Segment Segment Identification (111-AM) = "Ø3"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = National Provider Identifier (NPI)	M	*Imp Guide*: Required if Prescriber ID (411-DB) is used. *Payer Requirement*: Required for claims processing.
411-DB	PRESCRIBER ID	NPI	M	*Imp Guide*: Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement*: Required for claims processing.

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc. claims. 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, etc., health plan coverage for example. The Coordination of Benefits/Other Payments Segment is mandatory for a Claim Billing or Encounter request to a downstream payer. It is used to assist a downstream payer to uniquely identify a claim or encounter in case of duplicate processing. The Segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	X	

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

Coordination of Benefits/ Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-bill Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE	Blank = Not Specified Ø1 = Primary – First Ø2 = Secondary – Second Ø3 = Tertiary – Third Ø4 = Quaternary – Fourth Ø5 = Quinary – Fifth Ø6 = Senary – Sixth Ø7 = Septenary – Seventh Ø8 = Octonary – Eighth Ø9 = Nonary – Ninth	M	

Coordination of Benefits/ Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-bill Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
339-6C	OTHER PAYER ID QUALIFIER	Ø1 = National Payer ID Ø2 = Health Industry Number (HIN) Ø3 = Bank Information Number (BIN) Card Issuer ID Ø4 = National Association of Insurance Commissioners (NAIC) Ø5 = Medicare Carrier Number 99 = Other	RW	*Imp Guide*: Required if Other Payer ID (34Ø-7C) is used. *Payer Requirement*: Same as *Imp Guide*.
34Ø-7C	OTHER PAYER ID		RW	*Imp Guide*: Required if identification of the Other Payer is necessary for claim/encounter adjudication. *Payer Requirement*: Eight-digit MDHHS Other Carrier ID or BIN # will be accepted for processing.
443-E8	OTHER PAYER DATE		RW	*Imp Guide*: Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. *Payer Requirement*: Same as *Imp Guide*.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	*Imp Guide*: Required if Other Payer Amount Paid Qualifier (342-HC) is used. *Payer Requirement*: Same as *Imp Guide*.

Coordination of Benefits/ Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-bill Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø1 = Delivery Ø2 = Shipping Ø3 = Postage Ø4 = Administrative Ø5 = Incentive Ø6 = Cognitive Service Ø7 = Drug Benefit Ø9 = Compound Preparation Cost	RW	*Imp Guide*: Required if Other Payer Amount Paid (431-DV) is used. *Payer Requirement*: Same as *Imp Guide.*
431-DV	OTHER PAYER AMOUNT PAID		RW	*Imp Guide*: Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. *Payer Requirement*: Same as *Imp Guide.*
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	*Imp Guide*: Required if Other Payer Reject Code (472-6E) is used. *Payer Requirement:* Same as *Imp Guide.*

Coordination of Benefits/ Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-bill Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
472-6E	OTHER PAYER REJECT CODE		R	*Imp Guide*: Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered). *Payer Requirement*: Please refer to the claims processing manual for acceptable values.
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	*Imp Guide*: Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. *Payer Requirement*: Same as *Imp Guide*.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø6 = Patient Pay Amount (5Ø5-F5) as reported by previous payer	RW	*Imp Guide*: Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. *Payer Requirement:* Same as *Imp Guide.*
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	*Imp Guide*: Required if necessary for patient financial responsibility only billing. Required if necessary for state/federal/regulatory agency programs. Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted. *Payer Requirement*: Same as *Imp Guide*.

Coordination of Benefits/ Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-bill Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	RW	*Imp Guide*: Required if Benefit Stage Amount (394-MW) is used. *Payer Requirement*: Same as *Imp Guide*.
393-MV	BENEFIT STAGE QUALIFIER	Ø1 = Deductible Ø2 = Initial Benefit Ø3 = Coverage Gap Ø4 = Catastrophic Coverage	RW	*Imp Guide*: Required if Benefit Stage Amount (394-MW) is used. *Payer Requirement*: Same as *Imp Guide*.
394-MW	BENEFIT STAGE AMOUNT		RW	*Imp Guide*: 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 benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement*: Same as *Imp Guide*.

DUR/PPS Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required for B1 and B3 transactions if there is DUR information.

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	R***	*Imp Guide*: Required if DUR/PPS Segment is used. *Payer Requirement*: Same as *Imp Guide*.
439-E4	REASON FOR SERVICE CODE		RW***	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. *Payer Requirement*: Please refer to claims processing manual for the applicable DUR rejections.
44Ø-E5	PROFESSIONAL SERVICE CODE	MA= (Medication Administered) claims will deny if MA is not entered on the claim.	RW***	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. NCPDP recommends specific values for COVID-19 vaccine claims: Professional Service Code 'MA' (Medication Administered) claims will deny if MA is not entered on the claim *Payer Requirement*: Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement*: Please refer to claims processing manual for the allowed Professional service codes.

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
441-E6	RESULT OF SERVICE CODE		RW***	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. *Payer Requirement*: Please refer to claims processing manual for the allowed Result of Service Codes.

Compound Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	It is used for multi-ingredient prescriptions when each ingredient is reported.

Compound Segment Segment Identification (111-AM) = "1Ø"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	Blank = Not Specified Ø1 = Capsule Ø2 = Ointment Ø3 = Cream Ø4 = Suppository Ø5 = Powder Ø6 = Emulsion Ø7 = Liquid 1Ø = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	1 = Each 2 = Grams 3 = Milliliters	M	

Compound Segment Segment Identification (111-AM) = "1Ø"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3 = National Drug Code (NDC) - Formatted 11 digits (N)	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		RW	*Imp Guide*: Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement*: Required for each ingredient.
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	ØØ = Default Ø1 = AWP Ø2 = Local Wholesaler Ø3 = Direct Ø4 = EAC (Estimated Acquisition Cost) Ø5 = Acquisition Ø6 = MAC (Maximum Allowable Cost) Ø7 = Usual and Customary Ø8 = 34ØB/ Disproportionate Share Pricing Ø9 = Other 1Ø = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost) 13 = Special Patient Pricing	RW	*Imp Guide*: Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement*: Same as *Imp Guide*.

Clinical Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	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 Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	*Imp Guide*: Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. *Payer Requirement*: Same as *Imp Guide*.
492-WE	DIAGNOSIS CODE QUALIFIER	ØØ = Not Specified Ø1 = ICD9 Ø2 = ICD1Ø Ø3 = National Criteria Care Institute (NCCI) Ø4 = The Systematized Nomenclature of Human and Veterinary Medicine	RW***	*Imp Guide*: Required if Diagnosis Code (424-DO) is used. *Payer Requirement*: Same as *Imp Guide*.
		(SNOMED) Ø5 = Common Dental Terminology (CDT) Ø6 = Medi-Span Product Line Diagnosis Code Ø7 = American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV) Ø8 = First Databank Disease Code (FDBDX) Ø9 = First Databank FML Disease Identifier (FDB DxID) 99 = Other		

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
424-DO	DIAGNOSIS CODE		RW***	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement*: Same as *Imp Guide*.

Facility Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	It is used when these fields could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.

Facility Segment Segment Identification (111-AM) = "15"		Claim	Billing/Claim Re-bill	
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
336-8C	FACILITY ID		RW	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. *Payer Requirement*: Same as *Imp Guide*.
385-3Q	FACILITY NAME		RW	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. *Payer Requirement*: Same as *Imp Guide*.

End of Request Claim Billing/Claim Re-bill (B1/B3) Payer Sheet

Response Claim Billing/Claim Re-bill Payer Sheet

Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) Response

**Start of Response Claim Billing/Claim Re-bill (B1/B3) Payer Sheet **

General Information

Payer Name: Michigan Medicaid	Date:	
Plan Name/Group Name: MI01/MIMEDICAID	BIN:009737	PCN: P008009737

Claim Billing/Claim Re-bill PAID (or Duplicate of PAID) Response

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

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Response Transaction Header Segment		Claim Billing/Claim Re-bill Accepted/ Paid (or Duplicate of Paid)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1 Billing B3 Rebill	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M	01 – National Provider Identifier (NPI)
2Ø1-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging.

Response Message Segment Segment Identification (111-AM) = "2Ø"		Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation	
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
5Ø4-F4	MESSAGE		RW	*Imp Guide*: Required if text is needed for clarification or detail. *Payer Requirement*: Same as *Imp Guide*.

Response Insurance Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Insurance Segment Segment Identification (111-AM) = "25"		Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation	
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
3Ø1-C1	GROUP ID	MIMEDICAID	RW	*Imp Guide*: Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available. Required to identify the actual group that was used when multiple group coverages exist. *Payer Requirement*: Same as *Imp Guide*.

Response Insurance Segment Segment Identification (111-AM) = "25"		Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation	
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
545-2F	NETWORK REIMBURSEMENT ID		RW	*Imp Guide*: Required if needed to identify the network for the covered member. Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available. Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist. *Payer Requirement*: Same as *Imp Guide*.
568-J7	PAYER ID QUALIFIER		RW	*Imp Guide*: Required if Payer ID (569-J8) is used. *Payer Requirement*: Same as *Imp Guide*.
569-J8	PAYER ID		RW	*Imp Guide*: Required to identify the ID of the payer responding. *Payer Requirement*: Same as *Imp Guide*.
3Ø2-C2	CARDHOLDER ID	MI Medicaid ID Number <patient specific>	RW	*Imp Guide*: Required if the identification to be used in future transactions is different than what was submitted on the request. *Payer Requirement*: Same as *Imp Guide*.

Response Patient Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Patient Segment Segment Identification (111-AM) = "29"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
31Ø-CA	PATIENT FIRST NAME		R	*Imp Guide*: Required if known. *Payer Requirement*: Required for patient name validation.
311-CB	PATIENT LAST NAME		R	*Imp Guide*: Required if known. *Payer Requirement*: Required for patient name validation.
3Ø4-C4	DATE OF BIRTH	Format – CCYYMMDD	R	*Imp Guide*: Required if known. *Payer Requirement*: Same as *Imp Guide*.

Response Status Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	P = Paid D = Duplicate of Paid	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	*Imp Guide*: Required if needed to identify the transaction. *Payer Requirement*: Same as *Imp Guide*.
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.	RW***	*Imp Guide*: Required if Approved Message Code (548-6F) is used. *Payer Requirement*: Same as *Imp Guide*.

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
548-6F	APPROVED MESSAGE CODE		RW***	*Imp Guide*: Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. *Payer Requirement*: Same as *Imp Guide*.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	*Imp Guide*: Required if Additional Message Information (526-FQ) is used. *Payer Requirement*: Same as *Imp Guide*.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	*Imp Guide*: Required if Additional Message Information (526-FQ) is used. *Payer Requirement*: Same as *Imp Guide*.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	*Imp Guide*: Required when additional text is needed for clarification or detail. *Payer Requirement*: Same as *Imp Guide*.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW***	*Imp Guide*: Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:* Same as *Imp Guide*.

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	*Imp Guide*: Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement*: Same as *Imp Guide*.
55Ø-8F	HELP DESK PHONE NUMBER		RW	*Imp Guide*: Required if needed to provide a support telephone number to the receiver. *Payer Requirement*: Same as *Imp Guide*.

Response Claim Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

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

Response Pricing Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
5Ø5-F5	PATIENT PAY AMOUNT		R	Returned if the processor determines that the patient has payment responsibility for part/all of the claim.
5Ø6-F6	INGREDIENT COST PAID		R	Required if this value is used to arrive at the final reimbursement.
5Ø7-F7	DISPENSING FEE PAID		RW	*Imp Guide*: Required if this value is used to arrive at the final reimbursement. *Payer Requirement*: Same as *Imp Guide*.
521-FL	INCENTIVE AMOUNT PAID		RW	*Imp Guide*: Required if this value is used to arrive at the final reimbursement. Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø). *Payer Requirement*: Same as *Imp Guide*.
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	RW***	*Imp Guide*: Required if Other Amount Paid (565-J4) is used. *Payer Requirement*: Same as *Imp Guide*.
564-J3	OTHER AMOUNT PAID QUALIFIER		RW***	*Imp Guide*: Required if Other Amount Paid (565-J4) is used. *Payer Requirement*: Same as *Imp Guide*.
565-J4	OTHER AMOUNT PAID		RW***	*Imp Guide*: Required if this value is used to arrive at the final reimbursement. Required if Other Amount Claimed Submitted (48Ø-H9) is greater than zero (Ø). *Payer Requirement*: Same as *Imp Guide*.

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW***	*Imp Guide*: Required if this value is used to arrive at the final reimbursement. Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported. *Payer Requirement*: Same as *Imp Guide*.
5Ø9-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		RW	*Imp Guide*: Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing. *Payer Requirement*: Same as *Imp Guide*.
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT		RW	*Imp Guide*: Provided for informational purposes only. Payer Requirement: Same as Imp Guide.
513-FD	REMAINING DEDUCTIBLE AMOUNT		RW	Imp Guide: Provided for informational purposes only. *Payer Requirement*: Same as *Imp Guide*.
514-FE	REMAINING BENEFIT AMOUNT		RW	*Imp Guide*: Provided for informational purposes only. *Payer Requirement*: Same as *Imp Guide*.
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	*Imp Guide*: Required if Patient Pay Amount (5Ø5-F5) includes deductible. *Payer Requirement*: Same as *Imp Guide*.

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
518-FI	AMOUNT OF COPAY		RW	*Imp Guide*: Required if Patient Pay Amount (5Ø5-F5) includes co-pay as patient financial responsibility. *Payer Requirement*: Same as *Imp Guide*.
52Ø-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		RW	*Imp Guide*: Required if Patient Pay Amount (5Ø5-F5) includes amount exceeding periodic benefit maximum. *Payer Requirement*: Same as *Imp Guide*.
346-HH	BASIS OF CALCULATION—DISPENSING FEE		RW	*Imp Guide*: Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). *Payer Requirement*: Same as *Imp Guide*.
347-HJ	BASIS OF CALCULATION—COPAY		RW	*Imp Guide*: Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). *Payer Requirement*: Same as *Imp Guide*.
572-4U	AMOUNT OF COINSURANCE		RW	*Imp Guide*: Required if Patient Pay Amount (5Ø5-F5) includes co-insurance as patient financial responsibility. *Payer Requirement*: Same as *Imp Guide*.

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
573-4V	BASIS OF CALCULATION-COINSURANCE		RW	*Imp Guide*: Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). *Payer Requirement*: Same as *Imp* Guide.

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-billed/Paid (or Accept Duplicate of Paid)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW***	*Imp Guide*: Required if Reason For Service Code (439-E4) is used. *Payer Requirement*: Same as *Imp Guide*.
439-E4	REASON FOR SERVICE CODE		RW***	*Imp Guide*: Required if utilization conflict is detected. *Payer Requirement*: Same as *Imp Guide*.
528-FS	CLINICAL SIGNIFICANCE CODE		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. *Payer Requirement*: Same as *Imp Guide*.
529-FT	OTHER PHARMACY INDICATOR		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. *Payer Requirement*: Same as *Imp Guide*.
53Ø-FU	PREVIOUS DATE OF FILL		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict.

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-billed/Paid (or Accept Duplicate of Paid)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				Required if Quantity of Previous Fill (531-FV) is used. *Payer Requirement*: Same as *Imp Guide*.
531-FV	QUANTITY OF PREVIOUS FILL		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used. *Payer Requirement*: Same as *Imp Guide*.
532-FW	DATABASE INDICATOR		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. *Payer Requirement*: Same as *Imp Guide*.
533-FX	OTHER PRESCRIBER INDICATOR		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. *Payer Requirement*: Same as *Imp Guide*.
544-FY	DUR FREE TEXT MESSAGE		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. *Payer Requirement*: Same as *Imp Guide*.
57Ø-NS	DUR ADDITIONAL TEXT		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. *Payer Requirement*: Same as *Imp Guide*.

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		RW	*Imp Guide*: Required if Other Payer ID (34Ø-7C) is used. *Payer Requirement*: Same as *Imp Guide*.
34Ø-7C	OTHER PAYER ID		RW	*Imp Guide*: Required if other insurance information is available for coordination of benefits. *Payer Requirement*: Same as *Imp Guide*.
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	*Imp Guide*: Required if other insurance information is available for coordination of benefits. *Payer Requirement*: Same as *Imp Guide*.
356-NU	OTHER PAYER CARDHOLDER ID		RW	*Imp Guide*: Required if other insurance information is available for coordination of benefits. *Payer Requirement*: Same as *Imp Guide*.
992-MJ	OTHER PAYER GROUP ID		RW	*Imp Guide*: Required if other insurance information is available for coordination of benefits. *Payer Requirement*: Same as *Imp Guide*.
142-UV	OTHER PAYER PERSON CODE		RW	*Imp Guide:* Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer.

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-bill Accepted/Paid (or Duplicate of Paid)		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				Payer Requirement: Same as *Imp Guide*.
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	*Imp Guide*: Required if needed to provide a support telephone number of the other payer to the receiver. *Payer Requirement*: Same as *Imp Guide*.
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	*Imp Guide*: Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer. *Payer Requirement*: Same as *Imp Guide*.
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		RW	*Imp Guide*: Required when other coverage is known, which is after the Date of Service submitted. *Payer Requirement*: Same as *Imp Guide*.
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		RW	*Imp Guide*: Required when other coverage is known, which is after the Date of Service submitted. *Payer Requirement*: Same as *Imp Guide*.

Claim Billing/Claim Re-bill Accepted/Rejected Response

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

Response Transaction Header Segment		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1 Billing B3 Rebill	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M	01 – National Provider Identifier (NPI)
2Ø1-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

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

Response Insurance Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Insurance Segment Segment Identification (111-AM) = "25"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
3Ø1-C1	GROUP ID	MI MEDICAID	RW	*Imp Guide*: Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available. Required to identify the actual group that was used when multiple group coverages exist. *Payer Requirement*: Same as *Imp Guide*.
545-2F	NETWORK REIMBURSEMENT ID		RW	*Imp Guide*: Required if needed to identify the network for the covered member. Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available. Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist. *Payer Requirement*: Same as *Imp Guide*.
568-J7	PAYER ID QUALIFIER		RW	*Imp Guide*: Required if Payer ID (569-J8) is used. *Payer Requirement*: Same as *Imp Guide*.
569-J8	PAYER ID		RW	*Imp Guide*: Required to identify the ID of the payer responding. *Payer Requirement*: Same as *Imp Guide*.

Response Insurance Segment Segment Identification (111-AM) = "25"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
3Ø2-C2	CARDHOLDER ID	MI Medicaid ID Number <patient specific>	RW	*Imp Guide*: Required if the identification to be used in future transactions is different from what was submitted on the request. *Payer Requirement*: Same as *Imp Guide*.

Response Patient Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Patient Segment Segment Identification (111-AM) = "29"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
31Ø-CA	PATIENT FIRST NAME		R	*Imp Guide*: Required if known. *Payer Requirement*: Required for patient name validation.
311-CB	PATIENT LAST NAME		R	*Imp Guide*: Required if known. *Payer Requirement*: Required for patient name validation.
3Ø4-C4	DATE OF BIRTH	Format - CCYYMMDD	R	*Imp Guide*: Required if known. *Payer Requirement*: Same as *Imp Guide*.

Response Status Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Response Status Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	*Imp Guide*: Required if needed to identify the transaction. *Payer Requirement*: Same as *Imp Guide*.
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide*: Required if a repeating field is in error, to identify repeating field occurrence. *Payer Requirement*: Same as *Imp Guide*.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	*Imp Guide*: Required if Additional Message Information (526-FQ) is used. *Payer Requirement*: Same as *Imp Guide*.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	Imp Guide: Required if Additional Message Information (526-FQ) is used. Payer Requirement: Same as Imp Guide.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	*Imp Guide*: Required when additional text is needed for clarification or detail. *Payer Requirement*: Same as *Imp Guide*.

Response Status Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW***	*Imp Guide*: Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement*: Same as *Imp Guide*.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	*Imp Guide*: Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement*: Same as *Imp Guide*.
55Ø-8F	HELP DESK PHONE NUMBER		RW	*Imp Guide*: Required if needed to provide a support telephone number to the receiver. *Payer Requirement*: Same as *Imp Guide*.
987-MA	URL		RW	*Imp Guide*: Provided for informational purposes only to relay health care communications via the Internet. *Payer Requirement*: Same as *Imp Guide*.

Response Claim Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Response Claim Segment Identification (111-AM) = "22"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide*: For Transaction Code of "B1" or "B3", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW***	*Imp Guide*: Required if Reason For Service Code (439-E4) is used. *Payer Requirement*: Same as *Imp Guide*.
439-E4	REASON FOR SERVICE CODE		RW***	*Imp Guide*: Required if utilization conflict is detected. *Payer Requirement*: Same as *Imp Guide*.
528-FS	CLINICAL SIGNIFICANCE CODE		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. *Payer Requirement*: Same as *Imp Guide*.

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
529-FT	OTHER PHARMACY INDICATOR		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. *Payer Requirement*: Same as *Imp Guide*.
53Ø-FU	PREVIOUS DATE OF FILL		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. *Payer Requirement*: Same as *Imp Guide*.
531-FV	QUANTITY OF PREVIOUS FILL		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. Required if Previous Date of Fill (53Ø-FU) is used. *Payer Requirement*: Same as *Imp Guide*.
532-FW	DATABASE INDICATOR		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. *Payer Requirement*: Same as *Imp Guide*.
533-FX	OTHER PRESCRIBER INDICATOR		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. *Payer Requirement*: Same as *Imp Guide*.
544-FY	DUR FREE TEXT MESSAGE		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict.

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				Payer Requirement: Same as *Imp Guide*.
57Ø-NS	DUR ADDITIONAL TEXT		RW***	*Imp Guide*: Required if needed to supply additional information for the utilization conflict. *Payer Requirement*: Same as *Imp Guide*.

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Re-bill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	*Payer Requirement*: Same as *Imp Guide*.

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
339-6C	OTHER PAYER ID QUALIFIER		RW	*Imp Guide*: Required if Other Payer ID (34Ø-7C) is used. *Payer Requirement*: Same as *Imp Guide*.
34Ø-7C	OTHER PAYER ID		RW	*Imp Guide*: Required if other insurance information is available for coordination of benefits. *Payer Requirement*: Same as *Imp Guide*.

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	*Imp Guide*: Required if other insurance information is available for coordination of benefits. *Payer Requirement*: Same as *Imp Guide*.
356-NU	OTHER PAYER CARDHOLDER ID		RW	Imp Guide: Required if other insurance information is available for coordination of benefits. Payer Requirement: Same as Imp Guide.
992-MJ	OTHER PAYER GROUP ID		RW	*Imp Guide*: Required if other insurance information is available for coordination of benefits. *Payer Requirement*: Same as *Imp Guide*.
142-UV	OTHER PAYER PERSON CODE		RW	*Imp Guide*: Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer. *Payer Requirement*: Same as *Imp Guide*.
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	*Imp Guide*: Required if needed to provide a support telephone number of the other payer to the receiver. *Payer Requirement*: Same as *Imp Guide*.
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	*Imp Guide*: Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer. *Payer Requirement*: Same as *Imp Guide*.

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Re-bill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		RW	*Imp Guide*: Required when other coverage is known, which is after the Date of Service submitted. *Payer Requirement*: Same as *Imp Guide.*
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		RW	*Imp Guide*: Required when other coverage is known, which is after the Date of Service submitted. *Payer Requirement*: Same as *Imp Guide.*

Claim Billing/Claim Re-bill Rejected/Rejected Response

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

Response Transaction Header Segment		Claim Billing/Claim Re-bill Rejected/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1 Billing B3 Re-bill	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M	01 – National Provider Identifier (NPI)
2Ø1-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Re-bill Rejected/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

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

Response Status Segment Questions	Check	Claim Billing/Claim Re-bill Rejected/Rejected If Situational, Payer Situation
This segment is always sent is Segment is always sent	X	

Response Status Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Rejected/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER			*Imp Guide*: Required if needed to identify the transaction. *Payer Requirement*: Same as *Imp Guide*.
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide*: Required if a repeating field is in error, to identify repeating field occurrence. *Payer Requirement*: Same as *Imp Guide*.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	*Imp Guide*: Required if Additional Message Information (526-FQ) is used. *Payer Requirement*: Same as *Imp Guide*.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	*Imp Guide*: Required if Additional Message Information (526-FQ) is used. *Payer Requirement*: Same as *Imp Guide*.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	*Imp Guide*: Required when additional text is needed for clarification or detail. *Payer Requirement*: Same as *Imp Guide*.

Response Status Segment Identification (111-AM) = "21"		Claim Billing/Claim Re-bill Rejected/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW***	*Imp Guide*: Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:* Same as *Imp Guide*.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	*Imp Guide*: Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement*: Same as *Imp Guide*.
55Ø-8F	HELP DESK PHONE NUMBER		RW	*Imp Guide:* Required if needed to provide a support telephone number to the receiver. *Payer Requirement*: Same as *Imp Guide*.

****End of Response Claim Billing/Claim Re-bill (B1/B3) Payer Sheet ****

NCPDP Version D Claim Reversal

Request Claim Reversal Payer Sheet

Start of Request Claim Reversal (B2) Payer Sheet Template

General Information

Payer Name: Michigan Medicaid	Date:	
Plan Name/Group Name: MI01/MIMEDICAID	BIN: 009737	PCN: P008009737

Field Legend for Columns

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	R	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	RW	"Required when." The situations designated have qualifications for usage ("Required if x," "Not required if y").	Yes
NOT USED	NA	The Field is not used for the Segment in the designated Transaction. Not used are shaded for clarity for the Payer when creating the Template. For the actual Payer Template, not used fields must be deleted from the transaction (the row in the table removed).	No

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	9999 days

Claim Reversal Transaction

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

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

Transaction Header Segment		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN NUMBER	009737	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2 - Reversal	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	P008009737	M	
1Ø9-A9	TRANSACTION COUNT		M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M	01 = National Provider Identifier (NPI)
2Ø1-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
4Ø1-D1	DATE OF SERVICE	Format = CCYYMMDD	M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	0000000000	M	Assigned by Magellan Medicaid Administration

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

Insurance Segment Segment Identification (111-AM) = "Ø4"		Claim Reversal		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
3Ø2-C2	CARDHOLDER ID	MI MEDICAID ID	M	Medicaid ID Number <patient specific>
3Ø1-C1	GROUP ID	MIMEDICAID	RW	*Imp Guide*: Required if needed to match the reversal to the original billing transaction. *Payer Requirement*: Same as *Imp Guide*.

Claim Segment Questions	Check	Claim Billing/Claim Re-bill If Situational, Payer Situation
This Segment is always sent	X	
This payer supports partial fills	X	
This payer does not support partial fills		

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Reversal		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	M	*Imp Guide*: For Transaction Code of "B2," in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	00 = Not Specified 03 = National Drug Code	M	

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Reversal		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
4Ø7-D7	PRODUCT/SERVICE ID	NDC – for noncompound claims '0' – for compound claims	M	
4Ø3-D3	FILL NUMBER	0 1-99	RW	*Imp Guide*: Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (4Ø2-D2) occur on the same day. *Payer Requirement*: Same as *Imp Guide*.
3Ø8-C8	OTHER COVERAGE CODE		RW	Imp Guide: Required if needed by receiver to match the claim that is being reversed. Payer Requirement: For OCC =2, 3, 4, the COB request segment is required.

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

Pricing Segment Segment Identification (111-AM) = "11"		Claim Reversal		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	*Imp Guide*: Required if this field could result in contractually agreed upon payment. *Payer Requirement*: Same as *Imp Guide*.
43Ø-DU	GROSS AMOUNT DUE		RW	*Imp Guide*: Required if this field could result in contractually agreed upon payment. *Payer Requirement*: Same as *Imp Guide.*

Coordination of Benefits/ Other Payments Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

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

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

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Reversal		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW***	*Imp Guide*: Required if DUR/PPS Segment is used. *Payer Requirement*: Same as *Imp Guide*.
439-E4	REASON FOR SERVICE CODE		RW***	*Imp Guide*: Required if this field is needed to report drug utilization review outcome. *Payer Requirement*: Same as *Imp Guide*.
44Ø-E5	PROFESSIONAL SERVICE CODE		RW***	*Imp Guide*: Required if this field is needed to report drug utilization review outcome. *Payer Requirement*: Same as *Imp Guide*.

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Reversal		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
441-E6	RESULT OF SERVICE CODE		RW***	*Imp Guide*: Required if this field is needed to report drug utilization review outcome. *Payer Requirement*: Same as *Imp Guide*.
474-8E	DUR/PPS LEVEL OF EFFORT		RW***	*Imp Guide*: Required if this field is needed to report drug utilization review outcome. *Payer Requirement*: Same as Imp Guide.
End of Request Claim Reversal (B2) Payer Sheet *				

Response Claim Reversal Payer Sheet

Claim Reversal Accepted/Approved Response

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

General Information

Payer Name: Michigan Medicaid	Date:	
Plan Name/Group Name: MI01/MIMEDICAID	BIN: 009737	PCN: P008009737

Claim Reversal Accepted/Approved Response

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

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

Response Transaction Header Segment		Claim Reversal Accepted/Approved		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M	01 - National Provider Identifier (NPI)
2Ø1-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Reversal Accepted/Approved If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging.

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

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

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Accepted/Approved		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	*Imp Guide*: Required if needed to identify the transaction. *Payer Requirement*: Same as *Imp Guide*.
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.	RW***	*Imp Guide*: Required if Approved Message Code (548-6F) is used. *Payer Requirement*: Same as *Imp Guide*.
548-6F	APPROVED MESSAGE CODE		RW***	*Imp Guide*: Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity. *Payer Requirement*: Same as *Imp Guide*.

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Accepted/Approved		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	*Imp Guide*: Required if Additional Message Information (526-FQ) is used. *Payer Requirement*: Same as *Imp Guide*.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	*Imp Guide*: Required if Additional Message Information (526-FQ) is used. *Payer Requirement*: Same as *Imp Guide*.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	*Imp Guide*: Required when additional text is needed for clarification or detail. *Payer Requirement:* Same as *Imp Guide*.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW***	*Imp Guide*: Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement*: Same as *Imp Guide*.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	*Imp Guide*: Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement*: Same as *Imp Guide*.
55Ø-8F	HELP DESK PHONE NUMBER		RW	*Imp Guide*: Required if needed to provide a support telephone number to the receiver. *Payer Requirement*: Same as *Imp Guide.*

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

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

Response Pricing Segment Questions	Check	Claim Reversal Accepted/Approved If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

Response Pricing Segment Identification (111-AM) = "23"		Claim Reversal Accepted/Approved		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
521-FL	INCENTIVE AMOUNT PAID		RW	*Imp Guide*: Required if this field is reporting a contractually agreed upon payment. *Payer Requirement*: Same as *Imp Guide*.
5Ø9-F9	TOTAL AMOUNT PAID		RW	*Imp Guide*: Required if any other payment fields sent by the sender. *Payer Requirement*: Same as *Imp Guide*.

Claim Reversal Accepted/Rejected Response

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

Response Transaction Header Segment		Claim Reversal Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M	01 - National Provider Identifier (NPI)
2Ø1-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

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

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

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

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW***	*Imp Guide*: Required if a repeating field is in error, to identify repeating field occurrence. *Payer Requirement*: Same as *Imp Guide*.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	*Imp Guide*: Required if Additional Message Information (526-FQ) is used. *Payer Requirement*: Same as *Imp Guide*.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	*Imp Guide*: Required if Additional Message Information (526-FQ) is used. *Payer Requirement*: Same as *Imp Guide*.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	*Imp Guide*: Required when additional text is needed for clarification or detail. *Payer Requirement*: Same as *Imp Guide*.

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW***	*Imp Guide*: Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement*: Same as *Imp Guide*.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	*Imp Guide*: Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement*: Same as *Imp Guide*.
55Ø-8F	HELP DESK PHONE NUMBER		RW	*Imp Guide*: Required if needed to provide a support telephone number to the receiver. *Payer Requirement*: Same as *Imp Guide*.

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

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

Claim Reversal Rejected/Rejected Response

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

Response Transaction Header Segment		Claim Reversal Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M	01 - National Provider Identifier (NPI)
2Ø1-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Reversal Rejected/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

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

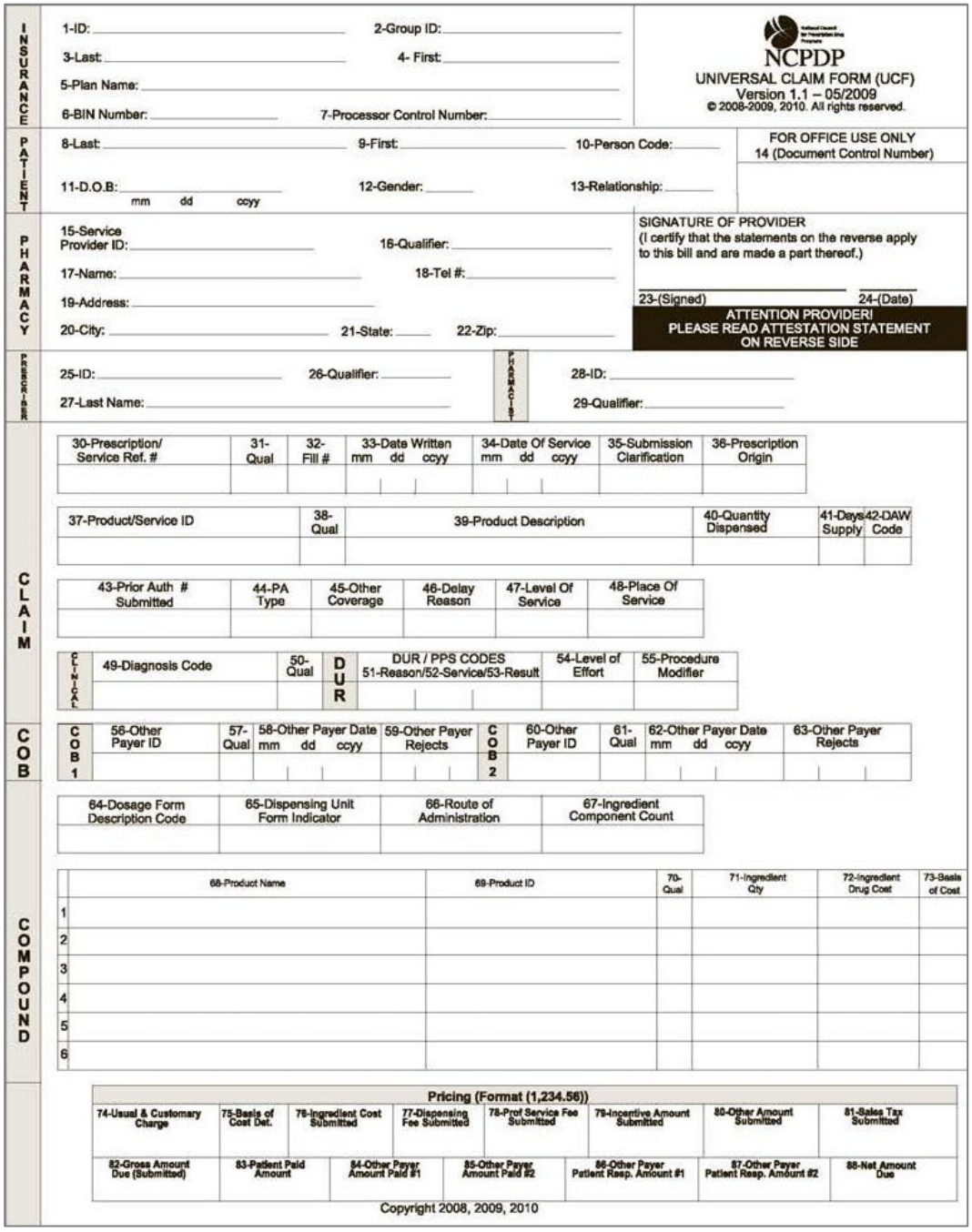
Response Status Segment Questions	Check	Claim Reversal Rejected/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Rejected/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW***	*Imp Guide*: Required if a repeating field is in error, to identify repeating field occurrence. *Payer Requirement*: Same as *Imp Guide*.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW***	*Imp Guide*: Required if Additional Message Information (526-FQ) is used. *Payer Requirement*: Same as *Imp Guide*.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW***	*Imp Guide*: Required if Additional Message Information (526-FQ) is used. *Payer Requirement*: Same as *Imp Guide*.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW***	*Imp Guide*: Required when additional text is needed for clarification or detail. *Payer Requirement*: Same as *Imp Guide*.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW***	*Imp Guide*: Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal Rejected/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement*: Same as *Imp Guide*.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	*Imp Guide*: Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement*: Same as *Imp Guide*.
55Ø-8F	HELP DESK PHONE NUMBER		RW	*Imp Guide*: Required if needed to provide a support telephone number to the receiver. *Payer Requirement*: Same as *Imp Guide*.
****End of Claim Reversal (B2) Response Payer Sheet ****				

Appendix B – Universal Claim Form, Version D.0

All paper pharmacy claims must be submitted to Magellan Medicaid Administration on a Universal Claim Form (UCF), which may be obtained from a pharmacy's wholesaler. The *Appendix G – Directory* at the end of this manual specifies, (1) an alternative source for universal claim forms, and (2) the Magellan Medicaid Administration address that pharmacies should mail UCF billings.



INSURANCE
1-ID: 2-Group ID:
3-Last: 4- First:
5-Plan Name:
6-BIN Number: 7-Processor Control Number:

NCPDP
UNIVERSAL CLAIM FORM (UCF)
Version 1.1 – 05/2009
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PATIENT
8-Last: 9-First: 10-Person Code:
11-D.O.B: mm dd ccyy 12-Gender: 13-Relationship:

FOR OFFICE USE ONLY
14 (Document Control Number)

PHARMACY
15-Service Provider ID: 16-Qualifier:
17-Name: 18-Tel #:
19-Address:
20-City: 21-State: 22-Zip:

SIGNATURE OF PROVIDER
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)
23-(Signed) 24-(Date)
ATTENTION PROVIDER!
PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE

PRESCRIBER
25-ID: 26-Qualifier:
27-Last Name:

PHARMACIST
28-ID:
29-Qualifier:

CLAIM

30-Prescription/ Service Ref. #	31-Qual	32-Fill #	33-Date Written mm dd ccyy	34-Date Of Service mm dd ccyy	35-Submission Clarification	36-Prescription Origin

37-Product/Service ID	38-Qual	39-Product Description	40-Quantity Dispensed	41-Days Supply	42-DAW Code

43-Prior Auth # Submitted	44-PA Type	45-Other Coverage	46-Delay Reason	47-Level Of Service	48-Place Of Service

CLINICAL 49-Diagnosis Code	50-Qual	DUR 51-Reason/52-Service/53-Result	54-Level of Effort	55-Procedure Modifier

COB

COB 1 56-Other Payer ID	57-Qual	58-Other Payer Date mm dd ccyy	59-Other Payer Rejects	COB 2 60-Other Payer ID	61-Qual	62-Other Payer Date mm dd ccyy	63-Other Payer Rejects

COMPOUND

64-Dosage Form Description Code	65-Dispensing Unit Form Indicator	66-Route of Administration	67-Ingredient Component Count

	68-Product Name	69-Product ID	70-Qual	71-Ingredient Qty	72-Ingredient Drug Cost	73-Basis of Cost
1						
2						
3						
4						
5						
6						

Pricing (Format (1,234.56))

74-Usual & Customary Charge	75-Basis of Cost Det.	76-Ingredient Cost Submitted	77-Dispensing Fee Submitted	78-Prof Service Fee Submitted	79-Incentive Amount Submitted	80-Other Amount Submitted	81-Sales Tax Submitted

82-Gross Amount Due (Submitted)	83-Patient Paid Amount	84-Other Payer Amount Paid #1	85-Other Payer Amount Paid #2	86-Other Payer Patient Resp. Amount #1	87-Other Payer Patient Resp. Amount #2	88-Net Amount Due

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Completion Instructions for the Universal Claim Form:

1. Complete all applicable areas on the front of the form. Type or print the information legibly. The use of correction fluid is not acceptable. Each area is numbered.
2. Verify patient information is correct and that patient named is eligible for benefits.
3. Ensure that the patient's signature is in the authorization box in the certification section on front side of the form for prescription(s) dispensed.
4. Do not exceed one set of DUR/PPS codes per claim.
5. Worker's Compensation Injury Claims – Michigan Medicaid does not accept this segment
6. Compound Prescriptions – Enter a single zero in the Product/Service I.D. area and list each ingredient name, NDC, quantity, and cost in the Product/Service I.D. box. The route of administration must also be included

   Note: Use a new Universal Claim Form for each compound prescription.
7. Home Infusion Therapy – Enter the appropriate NDC in the Product/Service I.D. area and enter "8" for the Prior Authorization Type Code. Home Infusion Therapy containing several products should be billed as a compound and not separately under each NDC

Definition of Values

In addition to the general guidelines above, pharmacies must use the code values listed when completing the following selected fields of the Universal Claim Form.

1. Other Coverage Code

   1 Not supported

   2 Other coverage exists – payment collected

   3 Other coverage exists – this claim not covered

   4 Other coverage exists – payment not collected

   5–8 Not supported
2. Person Code

   Code assigned to a specific person within a family. Code should always be cardholder.
3. Patient Gender Code

   1 Male

   2 Female
4. Patient Relationship Code

   1 Cardholder

5. Service Provider ID Qualifier

    01 NPI provider ID

6. Carrier ID in Workers Comp. Information

    Leave blank, unless workers compensation applies. Enter the Carrier Code assigned in Workers' Compensation Program.

7. Claim/Reference ID

    Enter the claim number assigned by Worker's Compensation Program. Michigan Medicaid does not accept this segment

8. Prescription Service Reference # Qualifier

    1 Rx billing

9. Quantity Dispensed

    Enter Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

10. Product/Service ID Qualifier (Qual)

    This is the code qualifying the value in Product/Service ID (NCPDP Field # 4Ø7-07).

    If compound is used, enter the most expensive NDC ingredient.

    03 National Drug Code (NDC)

11. Prior Authorization Type Code (PA Type)

    0 Not specified

    1 Prior Authorization

    2 Medical Certification

    3 EPSDT (Early Periodic Screening Diagnosis Treatment)

    4 Exemption from co-pay

    5 Exemption from Rx limits

    6 Family Planning Indicator

    7 Aid to Families with Dependent Children (AFDC)

    8 Payer defined exemption

12. Prescriber Provider ID Qualifier

    Use Qualifier "01 – NPI"

13. DUR/Professional Service Codes

    A Reason for service

B Professional Service code

C Result of Service

14. Basis of Cost Determination

Blank Not specified

00 Not specified

01 AWP (average wholesale price)

02 Local Wholesale

03 Direct

04 EAC (Estimated Acquisition Cost)

05 Acquisition

06 MAC (Maximum Allowable Cost)

07 Usual and Customary (U&C)

09 Other

15. Provider Id Qualifier

Use Qualifier "01" for the NPI number of the pharmacy

16. Other Payer ID Qualifier

99 Other – MDHHS Carrier ID

Note: For any other definitions or acceptable values, please refer to the *Payer Specs* section of this manual.

Appendix C – MDHHS Maintenance Drug List

A maximum supply of 102 days is allowed for drugs in the following therapeutic classes. Certain drugs may have specific quantity limits that supersede this list. See the MPPL at https://michigan.magellanrx.com/. Click the **Provider** and then **Documents** > **Other Drug Information**.

Therapeutic Class	Name
05	Bile Therapy
09	Antiparkinson Agents
11	Psychostimulants/Antidepressants
15	Bronchodilators
32	Antimalarials
33	Antivirals
34	TB Preparations
48	Anticonvulsants
52	Mineralocorticoids
55	Thyroid Preparations
56	Anti-Thyroid Preparations
58	Diabetic Therapy
61	Estrogens
62	Progesterone
63	Oral Contraceptives
66	Cholesterol Reducers
67	Digestants
69	Enzymes
70	Rauwolfia Preparations
71	Other Hypotensives
72	Vasodilators: Coronary
73	Vasodilators: Peripheral
74	Digitalis Preparations
75	Xanthine Derivatives
76	Cardiovascular Preparations: Other
77	Anticoagulants

Therapeutic Class	Name
79	Diuretics
80	Vitamins: Fat Soluble
81	Vitamins: Water Soluble
82	Multivitamin Preparations
83	Folic Acid Preparations
84	B Complex with Vitamin C
87	Electrolytes and Misc. Nutrients
88	Hematinics (with the exception of Darbepoetin, Epoetin, Filgrastim, and Pegfilgrastim)

Appendix D – Medicare Part B Covered Drugs

After payment is received from Part B for individuals dually enrolled in Medicare and Medicaid, MDHHS may pay the dual eligible's coinsurance up to the MDHHS allowable reimbursement levels. As explained in the Section 7.0 – Program Specifications of the Michigan Pharmacy Claims Processing Manual, pharmacies must call the Pharmacy Support Center to obtain override for the coinsurance payment.

Note: If a drug is not covered by Part B for reasons other, then patient deductible and a patient is eligible for both Medicare Part B and Medicare Part D, the claim should be billed to Medicare Part D for coverage.

Examples of Part B covered drugs include, but are not limited to, the following products:

Table 10 – Medicare Part B Covered Drugs

Description	Use
Busulfan	Cancer
Capecitabine	Cancer
Etoposide	Cancer
Melphalan	Cancer
Azathioprine	Immunosuppressive
Cyclophosphamide	Immunosuppressive
Cyclosporine	Immunosuppressive
Mycophenolate Mofetil	Immunosuppressive
Sirolimus	Immunosuppressive
Tacrolimus	Immunosuppressive
Methotrexate	Cancer
Acetylcysteine	Inhalation
Albuterol	Inhalation
Bitolterol	Inhalation
Budesonide	Inhalation
Cromolyn	Inhalation
Dornase Alpha	Inhalation
Ipratropium	Inhalation
Isoetharine	Inhalation
Metaproterenol	Inhalation

Description	Use
Pentamidine	Inhalation
Tobramycin	Inhalation
Dolasetron	Antiemetic
Dronabinol	Antiemetic
Granisetron	Antiemetic
Ondansetron	Antiemetic
Blood sugar diagnostics	Diabetic
Diabetic Supplies	Diabetic
Temozolomide	Cancer
Epoetin Alfa	Cancer
Darbepoetin Alfa	Cancer
Antihemophilic factors	Hemophilia
Factor IX preparations	Hemophilia
Azathioprine	Immunosuppressive
Cyclosporine	Immunosuppressive
Daclizumab	Immunosuppressive
Muromonab	Immunosuppressive
Mycophenolate	Immunosuppressive
Sirolimus	Immunosuppressive
Tacrolimus	Immunosuppressive
Ipratropium	Inhalation
Levalbuterol	Inhalation
Lymphocyte Immune Globulin	Immunosuppressive
Iloprost	Inhalation
Mycophenolate Sodium	Immunosuppressive
Arformoterol Tartrate	Inhalation

Appendix E – ProDUR

ProDUR Problem Types

Prospective drug utilization review encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of Magellan Medicaid Administration assists in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing assists the pharmacists to ensure that their patients receive the appropriate medications.

Because the Magellan Medicaid Administration ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. Magellan Medicaid Administration recognizes that the pharmacists use their education and professional judgments in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacists in performing their professional duties.

Listed below are all the ProDUR Conflict Codes within the Magellan Medicaid Administration system for the Michigan Medicaid Program.

Conflict Codes	Description	Disposition	Comments
DD	Drug-to-Drug Interaction	Deny Severity Level 1, alert only on others	May be overridden by the provider at the POS using the NCPDP DUR override codes.
ER	Early Refill	Deny	Pharmacies must contact the Magellan Medicaid Administration Pharmacy Support Center (1-877-624-5204) to request an override
LR	Late Refill	Alert only	
TD	Therapeutic Duplication	Deny on selected therapeutic classes, alert only on others	May be overridden by a pharmacy at the POS using the NCPDP DUR override codes
ID	Duplicate Ingredient	Alert only	
LD, HD	Minimum/Maximum Daily Dosing	Alert only	
PA	Drug-to-Pediatric Precaution	Alert only on Severity Level 1	
PA	Drug-to-Geriatric Precaution	Alert only on Severity Level 1	

Conflict Codes	Description	Disposition	Comments
DC	Drug-to-Inferred Disease	Alert only on Severity Level 1	
SR	Prerequisite Drug Therapy	Deny	
SX	Drug to Gender	Deny on Severity Levels 1 and 3	Pharmacies should contact the Magellan Medicaid Administration Clinical Support Center (1-877-864-9014) to request an override.
PP	Plan Protocol	Deny	Anti-Ulcer Call Clinical Support Center, after 102 days on high dose. See website for HD edit.

Drug Utilization Review (DUR) Fields

The following are the ProDUR edits that will deny for MDHHS:

- Drug/Drug Interactions – (Severity Level 1) – Provider overrides allowed.
- Early Refill – Contact Pharmacy Support Center to request an override.
- Therapeutic Duplication – (selected therapeutic classes) – Provider overrides allowed.
- Drug to Gender – (Severity Level 1) – Clinical Support Center may PA.
- Plan Protocol – Anti-Ulcer perquisite.

NCPDP	Message
88	DUR Reject Error

Also note that the following ProDUR edits will return a warning message only; i.e., an override is not necessary:

- Late Refill
- Duplicate Ingredient
- Minimum/Maximum Daily Dosing
- Drug to Pediatric Precautions – (Severity Level 1)
- Drug to Geriatric Precautions – (Severity Level 1)
- Drug to Inferred Disease – (Severity Level 1)
- Therapeutic Duplication – (Selected Therapeutic Classes)

Note: Provider overrides are processed on a per-claim (date of service only) basis. For quality of care purposes, pharmacists are required to retain documentation relative to these overrides.

DUR Reason for Service

The DUR Reason for Service is used to define the type of utilization conflict that was detected (NCPDP Field # 439-E4). For MDHHS, valid DUR Reason for Service codes are

- DD – Drug/Drug Interactions;
- TD – Therapeutic Duplication;
- ER – Early Refill; and
- SX – Drug/Sex Restriction.

NCPDP	Message
E4	M/I DUR Conflict/Reason for Service Code

DUR Professional Service

The DUR Professional Service (previously "Intervention Code") is used to define the type of interaction or intervention that was performed by the pharmacist (NCPDP Field # 44Ø-E5).

Valid DUR Professional Service Codes for the Michigan Medicaid Program are:

- 00 No Intervention;
- CC Coordination of Care;
- M0 Prescriber Consulted;
- PH Patient Medication History;
- P0 Patient Consulted; and
- R0 Pharmacist Consulted Other Source.

NCPDP	Message
E5	M/I DUR Intervention/Professional Service Code

DUR Result of Service

The DUR Result of Service (previously "Outcome Code") is used to define the action taken by the pharmacist in response to a ProDUR Reason for Service or the result of a pharmacist's professional service (NCPDP Field # 441-E6).

Valid DUR Result of Services for the Michigan Medicaid Program are:

- 1A Filled As Is, False Positive;
- 1B Filled Prescription As Is;
- 1C Filled With Different Dose;
- 1D Filled With Different Directions;

- 1F Filled With Different Quantity;
- 1G Filled With Prescriber Approval;
- 3B Recommendation Not Accepted; and
- 3C Discontinued Drug.

NCPDP	Message
E6	M/I DUR Outcome/Result of Service Code

Note: Provider overrides are allowed on claims denied for REASON FOR SERVICE DD (Drug-to-Drug Interactions) or TD (Therapeutic Duplications). Pharmacies must submit the allowed Professional Service and Result of Service codes as listed above.

If other values are submitted, the claim will continue to deny.

Prospective Drug Utilization Review (ProDUR)

ER/Early Refill	ER edit is hitting because of an LTC new admission or a readmission. Provider overrides PA by entering Submission Clarification Code field = "05." If the provider is trying to submit this override and the patient is NOT flagged with an ACTIVE LTC or Patient Attribute record, the claim will continue to deny. If this situation occurs, please advise the provider of the following: When a Medicaid beneficiary is admitted to a facility, the facility is to enter admission and discharge information directly in CHAMPS. This will result in real-time changes to the beneficiary's Program Enrollment Type (PET) code. The PET code precisely reflect the program and additional information on the living arrangement of the beneficiary. The facility would need to make the necessary changes in the system for the record to be updated.
D/Therapeutic Duplication	
DD/Drug-to-Drug Contraindication	

Drug/Drug Interactions and Therapeutic Duplication

POS Override Procedure

The Magellan Medicaid Administration POS system provides online assistance for the dispensing pharmacist. Incoming drug claims are compared to a beneficiary's pharmacy claims history file to detect potential drug/drug interactions and therapeutic duplications.

ProDUR denials are returned to the pharmacist when the POS process finds a SEVERITY LEVEL 1 problem as defined by First Databank. These denials are intended to assist the pharmacist awareness of beneficiary specific potential problems. These POS denials are not intended to replace the clinical judgment of the dispensing pharmacist.

Use the attached override procedure when you as the dispensing pharmacist have made a beneficiary-specific clinical decision to override the POS denial/alert. For quality of care purposes, pharmacists are required to retain documentation relative to these overrides.

Also attached are the NCPDP-specific codes that may be used in the respective Reason for Service, DUR Professional Service, and DUR Result of Service. Please note that each pharmacy's software may present the NCPDP standard override procedure fields differently.

DUR Reason for Service

The DUR Conflict Code is used to define the type of utilization conflict that was detected (NCPDP Field # 439-E4).

Valid DUR Conflict Codes for the Michigan Medicaid Program are

- DD Drug/Drug Interactions; and
- TD Therapeutic Duplication.

If one of the above two options are not used, the following error message will be returned:

NCPDP	Message
E4	M/I DUR Conflict/Reason for Service Code

Appendix F – POS Reject Codes and Messages

After a pharmacy online claims submission, the Magellan Medicaid Administration POS system returns messages that comply with NCPDP standards. Messages focus on ProDUR and POS rejection codes, as explained in the next sections.

ProDUR Alerts

If a pharmacy needs assistance interpreting ProDUR alert or denial messages from the Magellan Medicaid Administration POS system, the pharmacy should contact the Pharmacy Support Center Services at the time of dispensing. Refer to *Appendix G – Directory* at the end of this manual for contact information.

The Pharmacy Support Center can provide claims information on all error messages, which are sent by the ProDUR system. This information includes NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days' supply. All ProDUR alert messages appear at the end of the claims adjudication transmission. The following table provides the format that is used for these alert messages.

Table 11 – Record Format for ProDUR Alert Messages

Format	Field Definitions
?//	Up to three characters – Code transmitted to pharmacy when a conflict is detected (e.g., ER, HD, TD, DD)
Severity Index Code	One character – Code indicates how critical a given conflict is
Other Pharmacy Indicator	One character – Indicates if the dispensing provider also dispensed the first drug in question 1 = Your pharmacy 3 = Other pharmacy
Previous Date of Fill	Eight characters – Indicates previous fill date of conflicting drug in YYYYMMDD format
Quantity of Previous Fill	Five characters – Indicates quantity of conflicting drug previously dispensed
Data Base Indicator	One character – Indicates source of ProDUR message 1 = First Databank 4 = Processor Developed
Other Prescriber	One character – Indicates the prescriber of conflicting prescription 0 = No Value 1 = Same Prescriber 2 = Other Prescriber

Point-of-Sale Reject Codes and Messages

The following table lists the rejection codes and explanations, possible B1, B2, B3 fields that may be related to denied payment, and possible solutions for pharmacies experiencing difficulties. All edits may not apply to this program. Pharmacies requiring assistance should call the Magellan Medicaid Administration Pharmacy Support Center. Refer to *Appendix G – Directory* at the end of this manual for contact information.

Table 12 – Point-of-Sale Reject Codes and Messages

NCPDP Reject Code	NCPDP Reject Code Description	Comments
Ø1	M/I BIN Number	Use 009737
Ø2	M/I Version/Release number	Version allowed = 5.1 until 12/31/2011. D.0 beginning 01/01/2012
Ø3	M/I Transaction code	Transactions allowed = B1, B2, B3, E1
Ø4	M/I Processor control number	Use P008009737
Ø5	M/I Service Provider number	
Ø6	M/I Group ID	Use MIMEDICAID only
Ø7	M/I Cardholder ID	Use Michigan Medicaid Beneficiary ID number only.
Ø8	M/I Person code	
Ø9	M/I Date of Birth	Format is CCYYMMDD
1Ø	M/I Patient Gender Code	Allowed Values: 1 = Male 2 = Female
11	M/I Patient Relationship Code	Allowed Value: 1 = Cardholder
12	M/I Place of Service	
13	M/I Other coverage code	Allowed Values: 01 – No longer allowed 02 – Other coverage exists – payment collected 03 – Other coverage exists – claim not covered 04 – Other coverage exists – payment not collected 05. 06, 07, 08 – No longer allowed
14	M/I Eligibility Clarification Code	
15	M/I Date of Service	Format = CCYYYMMDD
16	M/I Prescription/Service Reference Number	Format is NNNNNNNNNNN

NCPDP Reject Code	NCPDP Reject Code Description	Comments
17	M/I Fill Number	Enter 00 for new prescription Enter range from 01 – 99 for a refill
19	M/I Days' supply	Format is NNN
2Ø	M/I Compound code	Allowed Values: 1 = Not a compound 2 = Compound
21	M/I Product/Service ID	Use 11-digit NDC only If a compound use a single zero
22	M/I Dispense as Written (DAW) /Product Selection code	Refer to *Section 7.4 – Maximum Allowable Cost (MAC) Rates* of this manual
23	M/I Ingredient Cost Submitted	
25	M/I Prescriber Id	Use the prescriber's NPI number only
26	M/I Unit Of Measure	
28	M/I Date prescription written	
27	Product Identifier not FDA/NSDE Listed	
29	M/I Number of refills authorized	
30	Reversal outside processor reversal window	
31	No matching paid claim found for reversal	
32	M/I Level of service	"Eff 10/1/2017 claims processed for ESO beneficiaries must be submitted with level of service 03 to attest that the service/drug is for an emergent condition"
33	M/I Prescription origin code	
34	M/I Submission Clarification Code	
35	M/I Primary Care Provider ID	
39	M/I Diagnosis code	
4Ø	Pharmacy Not Contracted with Plan On Date Of Service	Use NPI number only
41	Submit Bill to Other Processor or Primary Payer	Indicates the individual has other insurance coverage. See the additional message field for details
5Ø	Non-Matched Pharmacy Number	Use NPI number only Check beneficiary status
51	Non-Matched Group ID	Use MIMEDICAID only

NCPDP Reject Code	NCPDP Reject Code Description	Comments
52	Non-matched Cardholder ID	Use Michigan 10-digit Medicaid ID number (two zeros in front of the eight-digit Beneficiary ID)
53	Non-Matched Person Code	
54	Non-Matched Product/Service ID Number	Use 11-digit NDC only If a compound, use a single zero
55	Non-Matched Product Package size	
56	Non-Matched Prescriber ID	Use prescriber's NPI number
58	Non-Matched Primary Prescriber	
6Ø	Product/Service Not Covered for Patient Age	
61	Product/Service Not Covered for Patient Gender	
62	Patient/Card Holder ID Name Mismatch	
63	Institutionalized Patient Product/Service ID Not Covered	
64	Claim Submitted Does Not Match Prior Authorization	
65	Patient Is Not Covered	
66	Patient Age Exceeds Maximum Age	
67	Filled Before Coverage Effective	Use Michigan 10-digit Medicaid ID number (two zeros in front of the eight-digit Beneficiary ID)
68	Filled After Coverage Expired	Use Michigan 10-digit Medicaid ID number (two zeros in front of the eight-digit Beneficiary ID)
69	Filled After Coverage Terminated	
7Ø	Product/Service Not Covered – Plan Benefit Exclusion	Use 11-digit NDC; Drug not covered
71	Prescriber Is Not Covered	
72	Primary Prescriber Is Not Covered	
73	Refills Are Not Covered	
74	Other Carrier Payment Meets or Exceeds Payable	
75	Prior Authorization Required	Use 11-digit NDC – Drug requires PA
76	Plan Limitations Exceeded	Check days' supply and metric decimal quantity
77	Discontinued Product/Service ID Number	Use 11-digit NDC – NDC is obsolete
78	Cost Exceeds Maximum	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
79	Refill Too Soon	75 percent or more days' supply of previous claim has not been utilized
8Ø	Drug-Diagnosis Mismatch	
81	Claim Too Old	Check the date of service
82	Claim Is Post-Dated	Check the date of service
83	Duplicate Paid/Captured Claim	
84	Claim Has Not Been Paid/Captured	
85	Claim Not Processed	
86	Submit Manual Reversal	
87	Reversal Not Processed	Original claim not paid or Pharmacy NPI, Rx number, NDC does not match original claim
88	Dur Reject Error	
89	Rejected Claim Fees Paid	
9Ø	Host Hung Up	Processing host did not accept transmission
91	Host Response Error	Response not in appropriate format to be displayed
92	System Unavailable/Host Unavailable	Processing host did not accept transmission
95	Time Out	
96	Scheduled Downtime	
97	Payer unavailable	
98	Connection to Payer Is Down	
99	Host Processing Error	Do not retransmit claim
2Ø1	Patient Segment is not used for this Transaction Code	
2Ø2	Insurance Segment is not used for this Transaction Code	
2Ø3	Claim Segment is not used for this Transaction Code	
2Ø4	Pharmacy Provider Segment is not used for this Transaction Code	
2Ø5	Prescriber Segment is not used for this Transaction Code	
2Ø6	Coordination of Benefits/Other Payments Segment is not used for this Transaction Code	
2Ø7	Workers' Compensation Segment is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
2Ø8	DUR/PPS Segment is not used for this Transaction Code	
2Ø9	Pricing Segment is not used for this Transaction Code	
21Ø	Coupon Segment is not used for this Transaction Code	
211	Compound Segment is not used for this Transaction Code	
212	Prior Authorization Segment is not used for this Transaction Code	
213	Clinical Segment is not used for this Transaction Code	
214	Additional Documentation Segment is not used for this Transaction Code	
215	Facility Segment is not used for this Transaction Code	
216	Narrative Segment is not used for this Transaction Code	
217	Purchaser Segment is not used for this Transaction Code	
218	Service Provider Segment is not used for this Transaction Code	
219	Patient ID Qualifier is not used for this Transaction Code	
22Ø	Patient ID is not used for this Transaction Code	
221	Date of Birth is not used for this Transaction Code	
222	Patient Gender Code is not used for this Transaction Code	
223	Patient First Name is not used for this Transaction Code	
224	Patient Last Name is not used for this Transaction Code	
225	Patient Street Address is not used for this Transaction Code	
226	Patient City Address is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
227	Patient State/Province Address is not used for this Transaction Code	
228	Patient ZIP/Postal Zone is not used for this Transaction Code	
229	Patient Phone Number is not used for this Transaction Code	
23Ø	Place of Service is not used for this Transaction Code	
231	Employer ID is not used for this Transaction Code	
232	Smoker/Non-Smoker Code is not used for this Transaction Code	
233	Pregnancy Indicator is not used for this Transaction Code	
234	Patient E-Mail Address is not used for this Transaction Code	
235	Patient Residence is not used for this Transaction Code	
236	Patient ID Associated State/Province Address is not used for this Transaction Code	
237	Cardholder First Name is not used for this Transaction Code	
238	Cardholder Last Name is not used for this Transaction Code	
239	Home Plan is not used for this Transaction Code	
24Ø	Plan ID is not used for this Transaction Code	
241	Eligibility Clarification Code is not used for this Transaction Code	
242	Group ID is not used for this Transaction Code	
243	Person Code is not used for this Transaction Code	
244	Patient Relationship Code is not used for this Transaction Code	
245	Other Payer BIN Number is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
246	Other Payer Processor Control Number is not used for this Transaction Code	
247	Other Payer Cardholder ID is not used for this Transaction Code	
248	Other Payer Group ID is not used for this Transaction Code	
249	Medigap ID is not used for this Transaction Code	
25Ø	Medicaid Indicator is not used for this Transaction Code	
251	Provider Accept Assignment Indicator is not used for this Transaction Code	
252	CMS Part D Defined Qualified Facility is not used for this Transaction Code	
253	Medicaid ID Number is not used for this Transaction Code	
254	Medicaid Agency Number is not used for this Transaction Code	
255	Associated Prescription/Service Reference Number is not used for this Transaction Code	
256	Associated Prescription/Service Date is not used for this Transaction Code	
257	Procedure Modifier Code Count is not used for this Transaction Code	
258	Procedure Modifier Code is not used for this Transaction Code	
259	Quantity Dispensed is not used for this Transaction Code	
26Ø	Fill Number is not used for this Transaction Code	
261	Days' Supply is not used for this Transaction Code	
262	Compound Code is not used for this Transaction Code	
263	Dispense as Written (DAW)/Product Selection Code is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
264	Date Prescription Written is not used for this Transaction Code	
265	Number of Refills Authorized is not used for this Transaction Code	
266	Prescription Origin Code is not used for this Transaction Code	
267	Submission Clarification Code Count is not used for this Transaction Code	
268	Submission Clarification Code is not used for this Transaction Code	
269	Quantity Prescribed is not used for this Transaction Code	
27Ø	Other Coverage Code is not used for this Transaction Code	
271	Special Packaging Indicator is not used for this Transaction Code	
272	Originally Prescribed Product/Service ID Qualifier is not used for this Transaction Code	
273	Originally Prescribed Product/Service Code is not used for this Transaction Code	
274	Originally Prescribed Quantity is not used for this Transaction Code	
275	Alternate ID is not used for this Transaction Code	
276	Scheduled Prescription ID Number is not used for this Transaction Code	
277	Unit of Measure is not used for this Transaction Code	
278	Level of Service is not used for this Transaction Code	
279	Prior Authorization Type Code is not used for this Transaction Code	
28Ø	Prior Authorization Number Submitted is not used for this Transaction Code	
281	Intermediary Authorization Type ID is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
282	Intermediary Authorization ID is not used for this Transaction Code	
283	Dispensing Status is not used for this Transaction Code	
284	Quantity Intended to be Dispensed is not used for this Transaction Code	
285	Days' Supply Intended to be Dispensed is not used for this Transaction Code	
286	Delay Reason Code is not used for this Transaction Code	
287	Transaction Reference Number is not used for this Transaction Code	
288	Patient Assignment Indicator (Direct Member Reimbursement Indicator) is not used for this Transaction Code	
289	Route of Administration is not used for this Transaction Code	
29Ø	Compound Type is not used for this Transaction Code	
291	Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN) is not used for this Transaction Code	
292	Pharmacy Service Type is not used for this Transaction Code	
293	Associated Prescription/Service Provider ID Qualifier is not used for this Transaction Code	
294	Associated Prescription/Service Provider ID is not used for this Transaction Code	
295	Associated Prescription/Service Reference Number Qualifier is not used for this Transaction Code	
296	Associated Prescription/Service Reference Fill Number is not used for this Transaction Code	
297	Time of Service is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
298	Sales Transaction ID is not used for this Transaction Code	
299	Reported Payment Type is not used for this Transaction Code	
3ØØ	Provider ID Qualifier is not used for this Transaction Code	
3Ø1	Provider ID is not used for this Transaction Code	
3Ø2	Prescriber ID Qualifier is not used for this Transaction Code	
3Ø3	Prescriber ID is not used for this Transaction Code	
3Ø4	Prescriber ID Associated State/Province Address is not used for this Transaction Code	
3Ø5	Prescriber Last Name is not used for this Transaction Code	
3Ø6	Prescriber Phone Number is not used for this Transaction Code	
3Ø7	Primary Care Provider ID Qualifier is not used for this Transaction Code	
3Ø9	Primary Care Provider ID is not used for this Transaction Code	
3Ø9	Primary Care Provider Last Name is not used for this Transaction Code	
31Ø	Prescriber First Name is not used for this Transaction Code	
311	Prescriber Street Address is not used for this Transaction Code	
312	Prescriber City Address is not used for this Transaction Code	
313	Prescriber State/Province Address is not used for this Transaction Code	
314	Prescriber ZIP/Postal Zone is not used for this Transaction Code	
315	Prescriber Alternate ID Qualifier is not used for this Transaction Code	
316	Prescriber Alternate ID is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
317	Prescriber Alternate ID Associated State/Province Address is not used for this Transaction Code	
318	Other Payer ID Qualifier is not used for this Transaction Code	
319	Other Payer ID is not used for this Transaction Code	
32Ø	Other Payer Date is not used for this Transaction Code	
321	Internal Control Number is not used for this Transaction Code	
322	Other Payer Amount Paid Count is not used for this Transaction Code	
323	Other Payer Amount Paid Qualifier is not used for this Transaction Code	
324	Other Payer Amount Paid is not used for this Transaction Code	
325	Other Payer Reject Count is not used for this Transaction Code	
326	Other Payer Reject Code is not used for this Transaction Code	
327	Other Payer-Patient Responsibility Amount Count is not used for this Transaction Code	
328	Other Payer-Patient Responsibility Amount Qualifier is not used for this Transaction Code	
329	Other Payer-Patient Responsibility Amount is not used for this Transaction Code	
33Ø	Benefit Stage Count is not used for this Transaction Code	
331	Benefit Stage Qualifier is not used for this Transaction Code	
332	Benefit Stage Amount is not used for this Transaction Code	
333	Employer Name is not used for this Transaction Code	
334	Employer Street Address is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
335	Employer City Address is not used for this Transaction Code	
336	Employer State/Province Address is not used for this Transaction Code	
337	Employer Zip/Postal Code is not used for this Transaction Code	
338	Employer Phone Number is not used for this Transaction Code	
339	Employer Contact Name is not used for this Transaction Code	
34Ø	Carrier ID is not used for this Transaction Code	
341	Claim/Reference ID is not used for this Transaction Code	
342	Billing Entity Type Indicator is not used for this Transaction Code	
343	Pay To Qualifier is not used for this Transaction Code	
344	Pay To ID is not used for this Transaction Code	
345	Pay to Name is not used for this Transaction Code	
346	Pay to Street Address is not used for this Transaction Code	
347	Pay to City Address is not used for this Transaction Code	
348	Pay to State/Province Address is not used for this Transaction Code	
349	Pay To ZIP/Postal Zone is not used for this Transaction Code	
35Ø	Generic Equivalent Product ID Qualifier is not used for this Transaction Code	
351	Generic Equivalent Product ID is not used for this Transaction Code	
352	DUR/PPS Code Counter is not used for this Transaction Code	
353	Reason for Service Code is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
354	Professional Service Code is not used for this Transaction Code	
355	Result of Service Code is not used for this Transaction Code	
356	DUR/PPS Level of Effort is not used for this Transaction Code	
357	DUR Co-Agent ID Qualifier is not used for this Transaction Code	
358	DUR Co-Agent ID is not used for this Transaction Code	
359	Ingredient Cost Submitted is not used for this Transaction Code	
36Ø	Dispensing Fee Submitted is not used for this Transaction Code	
361	Professional Service Fee Submitted is not used for this Transaction Code	
362	Patient Paid Amount Submitted is not used for this Transaction Code	
363	Incentive Amount Submitted is not used for this Transaction Code	
364	Other Amount Claimed Submitted Count is not used for this Transaction Code	
365	Other Amount Claimed Submitted Qualifier is not used for this Transaction Code	
366	Other Amount Claimed Submitted is not used for this Transaction Code	
367	Flat Sales Tax Amount Submitted is not used for this Transaction Code	
368	Percentage Sales Tax Amount Submitted is not used for this Transaction Code	
369	Percentage Sales Tax Rate Submitted is not used for this Transaction Code	
37Ø	Percentage Sales Tax Basis Submitted is not used for this Transaction Code	
371	Usual and Customary Charge is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
372	Gross Amount Due is not used for this Transaction Code	
373	Basis of Cost Determination is not used for this Transaction Code	
374	Medicaid Paid Amount is not used for this Transaction Code	
375	Coupon Value Amount is not used for this Transaction Code	
376	Compound Ingredient Drug Cost is not used for this Transaction Code	
377	Compound Ingredient Basis of Cost Determination is not used for this Transaction Code	
378	Compound Ingredient Modifier Code Count is not used for this Transaction Code	
379	Compound Ingredient Modifier Code is not used for this Transaction Code	
38Ø	Authorized Representative First Name is not used for this Transaction Code	
381	Authorized Rep. Last Name is not used for this Transaction Code	
382	Authorized Rep. Street Address is not used for this Transaction Code	
383	Authorized Rep. City is not used for this Transaction Code	
384	Authorized Rep. State/Province is not used for this Transaction Code	
385	Authorized Rep. Zip/Postal Code is not used for this Transaction Code	
386	Prior Authorization Number - Assigned is not used for this Transaction Code	
387	Authorization Number is not used for this Transaction Code	
388	Prior Authorization Supporting Documentation is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
389	Diagnosis Code Count is not used for this Transaction Code	
39Ø	Diagnosis Code Qualifier is not used for this Transaction Code	
391	Diagnosis Code is not used for this Transaction Code	
392	Clinical Information Counter is not used for this Transaction Code	
393	Measurement Date is not used for this Transaction Code	
394	Measurement Time is not used for this Transaction Code	
395	Measurement Dimension is not used for this Transaction Code	
396	Measurement Unit is not used for this Transaction Code	
397	Measurement Value is not used for this Transaction Code	
398	Request Period Begin Date is not used for this Transaction Code	
399	Request Period Recert/Revised Date is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
4ØØ	Request Status is not used for this Transaction Code	
4Ø1	Length of Need Qualifier is not used for this Transaction Code	
4Ø2	Length of Need is not used for this Transaction Code	
4Ø3	Prescriber/Supplier Date Signed is not used for this Transaction Code	
4Ø4	Supporting Documentation is not used for this Transaction Code	
4Ø5	Question Number/Letter Count is not used for this Transaction Code	
4Ø6	Question Number/Letter is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
4Ø7	Question Percent Response is not used for this Transaction Code	
4Ø8	Question Date Response is not used for this Transaction Code	
4Ø9	Question Dollar Amount Response is not used for this Transaction Code	
41Ø	Question Numeric Response is not used for this Transaction Code	
411	Question Alphanumeric Response is not used for this Transaction Code	
412	Facility ID is not used for this Transaction Code	
413	Facility Name is not used for this Transaction Code	
414	Facility Street Address is not used for this Transaction Code	
415	Facility City Address is not used for this Transaction Code	
416	Facility State/Province Address is not used for this Transaction Code	
417	Facility ZIP/Postal Zone is not used for this Transaction Code	
418	Purchaser ID Qualifier is not used for this Transaction Code	
419	Purchaser ID is not used for this Transaction Code	
42Ø	Purchaser ID Associated State Code is not used for this Transaction Code	
421	Purchase Date of Birth is not used for this Transaction Code	
422	Purchaser Gender Code is not used for this Transaction Code	
423	Purchaser First Name is not used for this Transaction Code	
424	Purchaser Last Name is not used for this Transaction Code	
425	Purchaser Street Address is not used for this Transaction Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
426	Purchaser City Address is not used for this Transaction Code	
427	Purchaser State/Province Address is not used for this Transaction Code	
428	Purchaser ZIP/Postal Zone is not used for this Transaction Code	
429	Purchaser Country Code is not used for this Transaction Code	
43Ø	Purchaser Relationship Code is not used for this Transaction Code	
431	Released Date is not used for this Transaction Code	
432	Released Time is not used for this Transaction Code	
433	Service Provider Name is not used for this Transaction Code	
434	Service Provider Street Address is not used for this Transaction Code	
435	Service Provider City Address is not used for this Transaction Code	
436	Service Provider State/Province Address is not used for this Transaction Code	
437	Service Provider ZIP/Postal Zone is not used for this Transaction Code	
438	Seller ID Qualifier is not used for this Transaction Code	
439	Seller ID is not used for this Transaction Code	
44Ø	Seller Initials is not used for this Transaction Code	
441	Other Amount Claimed Submitted Grouping Incorrect	
442	Other Payer Amount Paid Grouping Incorrect	
443	Other Payer-Patient Responsibility Amount Grouping Incorrect	
444	Benefit Stage Amount Grouping Incorrect	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
445	Diagnosis Code Grouping Incorrect	
446	COB/Other Payments Segment Incorrectly Formatted	
447	Additional Documentation Segment Incorrectly Formatted	
448	Clinical Segment Incorrectly Formatted	
449	Patient Segment Incorrectly Formatted	
45Ø	Insurance Segment Incorrectly	
451	Transaction Header Segment Incorrectly Formatted	
452	Claim Segment Incorrectly Formatted	
453	Pharmacy Provider Segment Incorrectly Formatted	
454	Prescriber Segment Incorrectly Formatted	
455	Workers' Compensation Segment Incorrectly Formatted	
456	Pricing Segment Incorrectly Formatted	
457	Coupon Segment Incorrectly Formatted	
458	Prior Authorization Segment Incorrectly Formatted	
459	Facility Segment Incorrectly Formatted	
46Ø	Narrative Segment Incorrectly Formatted	
461	Purchaser Segment Incorrectly Formatted	
462	Service Provider Segment Incorrectly Formatted	
463	Pharmacy not contracted in Assisted Living Network	
464	Service Provider ID Qualifier Does Not Precede Service Provider ID	
465	Patient ID Qualifier Does Not Precede Patient ID	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
466	Prescription/Service Reference Number Qualifier Does Not Precede Prescription/Service Reference Number	
467	Product/Service ID Qualifier Does Not Precede Product/Service ID	
468	Procedure Modifier Code Count Does Not Precede Procedure Modifier Code	
469	Submission Clarification Code Count Does Not Precede Submission Clarification Code	
47Ø	Originally Prescribed Product/Service ID Qualifier Does Not Precede Originally Prescribed Product/Service Code	
471	Other Amount Claimed Submitted Count Does Not Precede Other Amount Claimed Amount and/or Qualifier	
472	Other Amount Claimed Submitted Qualifier Does Not Precede Other Amount Claimed Submitted	
473	Provider Id Qualifier Does Not Precede Provider ID	
474	Prescriber Id Qualifier Does Not Precede Prescriber ID	
475	Primary Care Provider ID Qualifier Does Not Precede Primary Care Provider ID	
476	Coordination of Benefits/Other Payments Count Does Not Precede Other Payer Coverage Type	
477	Other Payer ID Does Not Precede Other Payer ID Data Fields	
478	Other Payer ID Qualifier Does Not Precede Other Payer ID	
479	Other Payer Amount Paid Count Does Not Precede Other Payer Amount Paid and/or Qualifier	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
48Ø	Other Payer Amount Paid Qualifier Does Not Precede Other Payer Amount Paid	
481	Other Payer Reject Count Does Not Precede Other Payer Reject Code	
482	Other Payer-Patient Responsibility Amount Count Does Not Precede Other Payer-Patient Responsibility Amount and/or Qualifier	
483	Other Payer-Patient Responsibility Amount Qualifier Does Not Precede Other Payer-Patient Responsibility Amount	
484	Benefit Stage Count Does Not Precede Benefit Stage Amount and/or Qualifier	
485	Benefit Stage Qualifier Does Not Precede Benefit Stage Amount	
486	Pay to Qualifier Does Not Precede Pay To ID	
487	Generic Equivalent Product Id Qualifier Does Not Precede Generic Equivalent Product Id	
488	DUR/PPS Code Counter Does Not Precede DUR Data Fields	
489	DUR Co-Agent ID Qualifier Does Not Precede DUR Co-Agent ID	
49Ø	Compound Ingredient Component Count Does Not Precede Compound Product ID and/or Qualifier	
491	Compound Product ID Qualifier Does Not Precede Compound Product ID	
492	Compound Ingredient Modifier Code Count Does Not Precede Compound Ingredient Modifier Code	
493	Diagnosis Code Count Does Not Precede Diagnosis Code and/or Qualifier	
494	Diagnosis Code Qualifier Does Not Precede Diagnosis Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
495	Clinical Information Counter Does Not Precede Clinical Measurement data	
496	Length of Need Qualifier Does Not Precede Length Of Need	
497	Question Number/Letter Count Does Not Precede Question Number/Letter	
498	Accumulator Month Count Does Not Precede Accumulator Month	
499	Address Count Does Not Precede Address Data Fields	
5ØØ	Patient ID Qualifier Count Does Not Precede Patient ID Data Fields	
5Ø1	Prescriber ID Count Does Not Precede Prescriber ID Data Fields	
5Ø2	Prescriber Specialty Count Does Not Precede Prescriber Specialty	
5Ø3	Telephone Number Count Does Not Precede Telephone Number Data Fields	
5Ø4	Benefit Stage Qualifier Value Not Supported	
5Ø5	Other Payer Coverage Type Value Not Supported	
5Ø6	Prescription/Service Reference Number	
	Qualifier Value Not Supported	
5Ø7	Additional Documentation Type ID Value Not Supported	
5Ø8	Authorized Representative State/Province Address Value Not Supported	
5Ø9	Basis of Request Value Not Supported	
51Ø	Billing Entity Type Indicator Value Not Supported	
511	CMS Part D Defined Qualified Facility Value Not Supported	
512	Compound Code Value Not Supported	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
513	Compound Dispensing Unit Form Indicator Value Not Supported	
514	Compound Ingredient Basis of Cost Determination Value Not Supported	
515	Compound Product ID Qualifier Value Not Supported	
516	Compound Type Value Not Supported	
517	Coupon Type Value Not Supported	
518	DUR Co-Agent ID Qualifier Value Not Supported	
519	DUR/PPS Level of Effort Value Not Supported	
52Ø	Delay Reason Code Value Not Supported	
521	Diagnosis Code Qualifier Value Not Supported	
522	Dispensing Status Value Not Supported	
523	Eligibility Clarification Code Value Not Supported	
524	Employer State/Province Address Value Not Supported	
525	Facility State/Province Address Value Not Supported	
526	Header Response Status Value Not Supported	
527	Intermediary Authorization Type ID Value Not Supported	
528	Length of Need Qualifier Value Not Supported	
529	Level of Service Value Not Supported	
53Ø	Measurement Dimension Value Not Supported	
531	Measurement Unit Value Not Supported	
532	Medicaid Indicator Value Not Supported	
533	Originally Prescribed Product/Service ID Qualifier Value Not Supported	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
534	Other Amount Claimed Submitted Qualifier Value Not Supported	
535	Other Coverage Code Value Not Supported	
536	Other Payer-Patient Responsibility Amount Qualifier Value Not Supported	Acceptable value = 06 Patient pay amount as reported by previous payer
537	Patient Assignment Indicator (Direct Member Reimbursement Indicator) Value Not Supported	
538	Patient Gender Code Value Not Supported	
539	Patient State/Province Address Value Not Supported	
54Ø	Pay to State/ Province Address Value Not Supported	
541	Percentage Sales Tax Basis Submitted Value Not Supported	
542	Pregnancy Indicator Value Not Supported	
543	Prescriber ID Qualifier Value Not Supported	
544	Prescriber State/Province Address Value Not Supported	
545	Prescription Origin Code Value Not Supported	
546	Primary Care Provider ID Qualifier Value Not Supported	
547	Prior Authorization Type Code Value Not Supported	
548	Provider Accept Assignment Indicator Value Not Supported	
549	Provider ID Qualifier Value Not Supported	
55Ø	Request Status Value Not Supported	
551	Request Type Value Not Supported	
552	Route of Administration Value Not Supported	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
553	Smoker/Non-Smoker Code Value Not Supported	
554	Special Packaging Indicator Value Not Supported	
555	Transaction Count Value Not Supported	
556	Unit of Measure Value Not Supported	
557	COB Segment Present on A Non-COB Claim	
558	Part D Plan cannot coordinate benefits with another Part D Plan.	
559	ID Submitted is associated with a Sanctioned Pharmacy	
560	Pharmacy Not Contracted in Retail Network	
561	Pharmacy Not Contracted in Mail Order Network	
562	Pharmacy Not Contracted in Hospice Network	
563	Pharmacy Not Contracted in Veterans Admin Network	
564	Pharmacy Not Contracted in Military Network	
565	Patient Country Code Value Not Supported	
566	Patient Country Code Not Used for This Transaction	
571	Patient ID Assoc State/Province Not Supported	
572	Medigap ID Not Covered	
573	Presc AltID Assoc State/Province Not Supported	
574	Compound Ingredient Modifier Code Not Covered	
575	Purchaser State/Province Not Supported	
576	Service Provider State/Province Not Supported	
577	M/I Other Payer ID	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
578	Payer ID Count Does Not Match Number of Repetition	
579	Other Payer ID Count Exceeds Occurrences Supported	
580	Other Payer ID Count Grouping Incorrect	
581	Other Payer ID Count not used for this Code	
582	M/I Fill Number	
583	Provider ID Not Covered	
584	Service State/Province Code Not Supported	
585	Fill Number Value Not Supported	
586	Facility ID Not Covered	
587	Carrier ID Not Covered	
588	Alternate ID Not Covered	
589	Patient ID Not Covered	
590	Compound Dosage Form Not Covered	
591	Plan ID Not Covered	
592	DUR Co-Agent ID Not Covered	
593	M/I Date of Service	
594	Pay to ID Not Covered	
595	Assoc Presc/Service Provider ID Not Covered	
596	Compound Prep Time Not Used For This Code	
598	Multiple Patients Found	
599	Cardholder ID Matched, Last Name Did Not	
600	Coverage Outside Submitted Date Of Service	
601	AuthType ID not before Auth ID	
602	Presc/Svc ID Qualifier not before Presc/Svc ID	
603	Presc Alt ID Qualifier not before Presc Alt ID	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
604	Purchaser ID Qualifier not before Purchaser ID	
605	Seller ID Qualifier Does Not Precede Seller ID	
606	Brand Drug / Specific Labeler Code Required	
607	N1/N3 cannot be matched to a claim B1/B3	
608	Alt Drug Therapy Req Prior to Sub Prod ID	
609	COB Claim Not Req Patient Liability Amount is Zero	
610	N1/N3 matched to rev/rej claim for Pt D BIN PCN	
612	LTC Appropriate Dispensing Invalid SCC Combination	
613	Packaging Method or Disp Freq Is Inappropriate LTC Short Cycle	
614	Uppercase Character(s) Required	
615	Ing Cost Det 14 Req if Compound Ing Qty 0 but over $0	
616	Sub Clarification Cd 8 Req when Compound Ing Qty Is 0	
617	Compound Ingredient Drug Cost Cannot Be Negative Amt	
618	Prescriber DEA does not allow this drug DEA class	
619	Prescriber Type 1 NPI Required	
620	This Prod/Serv may be covered under Medicare Part D	
621	This Medicaid Patient is Medicare Eligible	
623	M/I Authorized Representative Country Code	
624	M/I Employer Country Code	
625	M/I Entity Country Code	
627	M/I Facility Country Code	
628	M/I Patient ID Associated Country Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
629	M/I Pay to Country Code	
630	M/I Prescriber Alternate ID Assoc Country Code	
631	M/I Prescriber ID Associated Country Code	
632	M/I Prescriber Country Code	
633	M/I Purchaser ID Associated Country Code	
634	Authorized Rep Country Code Not Supported	
635	M/I Employer Country Code Value Not Supported	
637	M/I Entity Country Code Value Not Supported	
638	M/I Facility Country Code Value Not Supported	
639	M/I Patient ID Assoc Country Code Not Supported	
640	M/I Pay to Country Code Value Not Supported	
641	M/I Prescriber Alt ID Assoc Country Code Not Supported	
642	M/I Prescriber ID Assoc Country Code Not Supported	
643	M/I Prescriber Country Code Value Not Supported	
644	M/I Purchaser ID Assoc Country Code Not Supported	
645	Repkgd prod not covered by contract	
646	Not Elig Due to Nonpayment Of Premium-Pt Contact Plan	
647	Quantity Prescribed Required For CII Prescription	
648	Qty Prescribed Does Not Match Qty on Orig CII Disp	
649	Cumulative Qty For Rx Number Exceeds Qty Prescr	
650	Fill Date Greater than 60 DS from CII Date Prescr	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
769	Pt D paid B1/B3 found but no N1/N3 match for N2	
770	No Pt D paid B1/B3 and no N1/N3 match for N2	
771	Comp has unidentifiable ingredient(s). No SCC allowed	
772	Comp not payable non-covered ingredient(s). No SCC allowed	
773	Prescriber is not listed Medicare enrollment file	
774	Prescriber Medicare enroll period outside DOS	
775	Prescriber not in Medicare FFS active enroll file	
776	Pharmacy enrollment with Medicare FFS terminated	
777	Cannot verify state license auth for prescriber	
816	Drug Benefit Exclusion, may be covered by Medical	
817	Drug Benefit Exclusion, covered under Medical	
818	Med Administration Not Covered, Plan Benefit Exclusion	
819	Enrollment File shows Medicare As Primary Coverage	
820	N1/N3 match to rev/rej clm not sub to PtD BIN PCN	
821	N1/N3 match to paid claim not sub to Pt D BIN PCN	
822	Drug not assoc w term illness/cond. No hospice cov	
823	Drug not covered by hospice, Pt D. Check other cov	
824	Multi-transaction transmission not allowed	
826	Prescriber NPI Submitted Not Found Within NPI File	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
827	Pharm Temporarily Suspended From Processing Claims	
828	Plan/Beneficiary Case Management Restriction in Place	
829	Notify: Claim Not Covered-Pt D Actv, NPI Reqs not met	
830	Workers' Comp Or P&C Adjuster Auth Required	
831	PrdctSrvceID CarveOut, Bill Medicaid Fee For Service	
832	Prescriber NPI Not Found	
833	Accumulator Year Is Not Within ATBT Timeframe	
834	M/I Provider First Name	
835	M/I Provider Last Name	
836	M/I Facility ID Qualifier	
837	Facility ID Value Not Supported	
838	M/I Original Manufacturer Product ID	
839	M/I Original Manufacturer Product ID Qualifier	
840	Original Manufacturer ProductID Value Not Supported	
889	Prescriber Not Enrolled in State Medicaid Program	
890	Pharmacy Not Enrolled in State Medicaid Program	
1C	M/I Smoker/Non-Smoker Code	
1R	Version/Release Not Supported	
1S	Transaction Code/Type Not Supported	
1T	PCN Must Contain Processor/Payer Assigned Value	
1U	Transaction Count Does Not Match Number of Transactions	
1V	Multiple Transactions Not Supported	
1W	Multi-Ingredient Compound Must be A Single Transaction	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
1X	Vendor Not Certified For Processor/Payer	
1Y	Claim Segment Required for Adjudication	
1Z	Clinical Segment Required for Adjudication	
2A	M/I Medigap ID	
2B	M/I Medicaid Indicator	Acceptable value = MI
2C	M/I Pregnancy Indicator	
2D	M/I Provider Accept Assignment Indicator	
2E	M/I Primary Care Provider ID Qualifier	
2G	M/I Compound Ingredient Modifier Code Count	
2H	M/I Compound Ingredient Modifier Code	
2J	M/I Prescriber First Name	
2K	M/I Prescriber Street Address	
2M	M/I Prescriber City Address	
2N	M/I Prescriber State/Province Address	
2P	M/I Prescriber Zip/Postal Zone	
2Q	M/I Additional Documentation Type ID	
2R	M/I Length of Need	
2S	M/I Length of Need Qualifier	
2T	M/I Prescriber/Supplier Date Signed	
2U	M/I Request Status	
2V	M/I Request Period Begin Date	
2W	M/I Request Period Recert/Revised Date	
2X	M/I Supporting Documentation	
2Z	M/I Question Number/Letter Count	
3A	M/I Request Type	
3B	M/I Request Period Date-Begin	
3C	M/I Request Period Date-End	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
3D	M/I Basis Of Request	
3E	M/I Authorized Representative First Name	
3F	M/I Authorized Representative Last Name	
3G	M/I Authorized Representative Street Address	
3H	M/I Authorized Representative City Address	
3J	M/I Authorized Representative State/Prov Address	
3K	M/I Authorized Representative Zip/Postal	
	Zone	
3M	M/I Prescriber Phone Number	
3N	M/I Prior Authorized Number Assigned	
3P	M/I Authorization Number	
3Q	M/I Facility Name	
3R	Prior Authorization Not Required	
3S	M/I Prior Authorization Supporting Documentation	
3T	Active Prior Auth Exists Resubmit At Expiration of Prior Authorization	
3W	Prior Authorization In Process	
3X	Authorization Number Not Found	
3Y	Prior Authorization Denied	
4B	M/I Question Number/Letter	
4C	M/I Coordination Of Benefits/Other Payments Count	
4D	M/I Question Percent Response	
4E	M/I Primary Care Provider Last Name	
4G	M/I Question Date Response	
4H	M/I Question Dollar Amount Response	
4J	M/I Question Numeric Response	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
4K	M/I Question Alphanumeric Response	
4M	Compound Ingredient Modifier Code Count Does Not Match Number of Repetitions	
4N	Question Number/Letter Count Does Not Match Number of Repetitions	
4P	Question Number/Letter Not Valid for Identified Document	
4Q	Question Response Not Appropriate for Question Number/Letter	
4R	Required Question Number/Letter Response for Indicated Document Missing	
4S	Compound Product ID Requires a Modifier Code	
4T	M/I Additional Documentation Segment	
4W	Must Fill Through Specialty Pharmacy	
4X	M/I Patient Residence	
4Y	Patient Residence not supported by plan	
4Z	Place of Service Not Support By Plan	
5C	M/I Other Payer Coverage Type	
5E	M/I Other Payer Reject Count	
5J	M/I Facility City Address	
6C	M/I Other Payer ID Qualifier	
6D	M/I Facility Zip/Postal Zone	
6E	M/I Other Payer Reject Code	
6G	Coordination Of Benefits/Other Payments Segment Required For Adjudication	
6H	Coupon Segment Required For Adjudication	
6J	Insurance Segment Required For Adjudication	
6K	Patient Segment Required For Adjudication	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
6M	Pharmacy Provider Segment Required For Adjudication	
6N	Prescriber Segment Required For Adjudication	
6P	Pricing Segment Required For Adjudication	
6Q	Prior Authorization Segment Required For Adjudication	
6R	Worker's Compensation Segment Required For Adjudication	
6S	Transaction Segment Required For Adjudication	
6T	Compound Segment Required For Adjudication	
6U	Compound Segment Incorrectly Formatted	
6V	Multi-ingredient Compounds Not Supported	
6W	DUR/PPS Segment Required For Adjudication	
6X	DUR/PPS Segment Incorrectly Formatted	
6Y	Not Authorized to Submit Electronically	
6Z	Provider Not Eligible To Perform Service/Dispense Product	
7A	Provider Does Not Match Authorization On File	
7B	Service Provider ID Qualifier Value Not Supported For Processor/Payer	
7C	M/I Other Payer ID	
7D	Non-Matched DOB	
7E	M/I DUR/PPS Code Counter	
7F	Future date not allowed for Date of Birth	
7G	Future Date Not Allowed for DOB	
7H	Non-Matched Gender Code	
7J	Patient Relationship Code Not Supported	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
7K	Discrepancy Between Other Coverage Code And Other Payer Amount	
7M	Discrepancy Between Other Coverage Code And Other Coverage Information On File	
7N	Patient ID Qualifier Submitted Not Supported	
7P	Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers	
7Q	Other Payer ID Qualifier Not Supported	
7R	Other Payer Amount Paid Count Exceeds Number of Supported Groupings	
7S	Other Payer Amount Paid Qualifier Not Supported	
7T	Quantity Intended To Be Dispensed Required For Partial Fill Transaction	
7U	Days' Supply Intended To Be Dispensed Required For Partial Fill Transaction	
7V	Duplicate Refills	
7W	Refills Exceed allowable Refills	
7X	Days' Supply Exceeds Plan Limitation	
7Y	Compounds Not Covered	
7Z	Compound Requires Two Or More Ingredients	
8A	Compound Requires At Least One Covered Ingredient	
8B	Compound Segment Missing On A Compound Claim	
8C	M/I Facility ID	
8D	Compound Segment Present On A Non-Compound Claim	
8E	M/I DUR/PPS Level Of Effort	
8G	Product/Service ID (4Ø7-D7) Must Be A Single Zero "Ø" For Compounds	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
8H	Product/Service Only Covered On Compound Claim	
8J	Incorrect Product/Service ID For Processor/Payer	
8K	DAW Code Not Supported	
8M	Sum Of Compound Ingredient Costs Does Not Equal Ingredient Cost Submitted	
8N	Future Date Prescription Written Not Allowed	
8P	Date Written Different On Previous Filling	
8Q	Excessive Refills Authorized	
8R	Submission Clarification Code Not Supported	
8S	Basis Of Cost Not Supported	
8T	U&C Must Be Greater Than Zero	
8U	GAD Must Be Greater Than Zero	
8V	Negative Dollar Amount Is Not Supported In The Other Payer Amount Paid Field	
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid	
8X	Collection From Cardholder Not Allowed	
8Y	Excessive Amount Collected	
8Z	Product/Service ID Qualifier Value Not Supported	
9B	Reason For Service Code Value Not Supported	
9C	Professional Service Code Value Not Supported	
9D	Result Of Service Code Value Not Supported	
9E	Quantity Does Not Match Dispensing Unit	
9G	Quantity Dispensed Exceeds Maximum Allowed	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
9H	Quantity Not Valid For Product/Service ID Submitted	
9J	Future Other Payer Date Not Allowed	
9K	Compound Ingredient Component Count Exceeds Number Of Ingredients Supported	
9M	Minimum Of Two Ingredients Required	
9N	Compound Ingredient Quantity Exceeds Maximum Allowed	
9P	Compound Ingredient Drug Cost Must Be Greater Than Zero	
9Q	Route Of Administration Submitted Not Covered	
9R	Prescription/Service Reference Number Qualifier Submitted Not Covered	
9S	Future Associated Prescription/Service Date Not Allowed	
9T	Prior Authorization Type Code Submitted Not Covered	
9U	Provider ID Qualifier Submitted Not Covered	
9V	Prescriber ID Qualifier Submitted Not Covered	
9W	DUR/PPS Code Counter Exceeds Number Of Occurrences Supported	
9X	Coupon Type Submitted Not Covered	
9Y	Compound Product ID Qualifier Submitted Not Covered	
9Z	Duplicate Product ID In Compound	
A1	ID Submitted is associated with a Sanctioned Prescriber	
A2	ID Submitted is associated to a Deceased Prescriber	
A5	Not Covered Under Part D Law	
A6	This Medication May Be Covered Under Part B	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
A7	M/I Internal Control Number	
A9	M/I Transaction Count	
AA	Patient Spenddown Not Met	
AB	Date Written Is After Date Filled	
AC	Product Not Covered Non-Participating Manufacturer	
AD	Billing Provider Not Eligible To Bill This Claim Type	
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare	
AF	Patient Enrolled Under Managed Care	
AG	Days' Supply Limitation For Product/Service	
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients	
AJ	Generic Drug Required	
AK	M/I Software Vendor/Certification ID	
AM	M/I Segment Identification	
AQ	M/I Facility Segment	
B2	M/I Service Provider ID Qualifier	Use 01 = NPI
BA	Compound Basis of Cost Determination Submitted Not Covered	
BB	Diagnosis Code Qualifier Submitted Not Covered	
BC	Future Measurement Date Not Allowed	
BD	Sender Not Authorized To Submit File Type	
BE	M/I Professional Service Fee Submitted	
BF	M/I File Type	
BG	Sender ID Not Certified For Processor/Payer	
BH	M/I Sender ID	
BJ	Transmission Type Submitted Not Supported	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
BK	M/I Transmission Type	
CA	M/I Patient First Name	Check the patient's first name
CB	M/I Patient Last Name	Check the patient's last name
CC	M/I Cardholder First Name	
CD	M/I Cardholder Last Name	
CE	M/I Home Plan	
CF	M/I Employer Name	
CG	M/I Employer Street Address	
CH	M/I Employer City Address	
CI	M/I Employer State/Province address	
CJ	M/I Employer Zip Postal Zone	
CK	M/I Employer Phone Number	
CL	M/I Employer Contact Name	
CM	M/I Patient Street Address	
CN	M/I Patient City Address	
CO	M/I Patient State/Province Address	
CP	M/I Patient Zip Posta Zone	
CQ	M/I Patient Phone Number	
CR	M/I Carrier ID	
CW	M/I Alternate ID	
CX	M/I Patient ID Qualifier	
CY	M/I Patient ID	
CZ	M/I Employer ID	
DC	M/I Dispensing Fee Submitted	
DN	M/I Basis Of Cost Determination	
DQ	M/I Usual And Customary Charge	
DR	M/I Prescriber Last Name	
DT	M/I Special Packaging indicator	
DU	M/I Gross Amount Due	
DV	M/I Other Payer Amount Paid	
DX	M/I Patient Paid Amount Submitted	Enter amount received from other payer(s) for this claim
DY	M/I Date Of Injury	
DZ	M/I Claim/Reference ID	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
E1	M/I Product/Service ID Qualifier	
E2	M/I Route of Administration	
E3	M/I Incentive amount submitted	
E4	M/I Reason For Service Code	Refer to section *E.3 – DUR Reason for Service* of this manual
E5	M/I Professional Service Code	Refer to section *E.4 – DUR Professional Service* of this manual
E6	M/I Result Of Service Code	Refer to section *E.5 – DUR Result of Service* of this manual
E7	M/I Quantity Dispensed	The correct formal is 9 (7).999
E8	M/I Other Payer Date	
E9	M/I Provider ID	
EA	M/I Originally Prescribed Product/Service Code	
EB	M/I Originally Prescribed Quantity	
EC	M/I Compound Ingredient Component Count	
ED	M/I Compound Ingredient Quantity	
EE	M/I Compound Ingredient Drug Cost	
EF	M/I Compound Dosage Form Description Code	
EG	M/I Compound Dispensing Unit Form	
	Indicator	
EH	M/I Compound Route Of Administration	Route of admin must be submitted if the compound segment is billed
EJ	M/I Originally Prescribed Product/Service ID Qualifier	
EK	M/I Scheduled Prescription ID Number	
EM	M/I Prescription/Service Reference Number Qualifier	
EN	M/I Associated Prescription/Service Reference Number	
EP	M/I Associated Prescription/Service Date	
ER	M/I Procedure Modifier Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
ET	M/I Quantity Prescribed	Required when a transmission is for a Scheduled II drug as defined in 21 CFR 1308.12 and per CMS 0055-F (Compliance Date 09/21/2020
EU	M/I Prior Authorization Type Code	Required when needed to designate prior authorization and/or override conditions.
EV	M/I Prior Authorization Number Submitted	
EW	M/I Intermediary Authorization Type ID	
EX	M/I Intermediary Authorization ID	
EY	M/I Provider ID Qualifier	
EZ	M/I Prescriber ID Qualifier	Use 01 = NPI
FO	M/I Plan ID	
G1	M/I Compound Type	
G2	M/I CMS Part D Defined Qualified Facility	
G4	Physician must contact plan	
G5	Pharmacist must contact plan	
G6	Pharmacy Not Contracted in Specialty Network	
G7	Pharmacy Not Contracted in Home Infusion Network	
G8	Pharmacy Not Contracted in Long-Term Care Network	
G9	Pharmacy Not Contracted in 9Ø-Day Retail Network (this message would be used when the pharmacy is not contracted to provide a 9Ø days' supply of drugs)	
GE	M/I Percentage Sales Tax Amount Submitted	
H1	M/I Measurement Time	
H2	M/I Measurement Dimension	
H3	M/I Measurement Unit	
H4	M/I Measurement Value	
H6	M/I DUR Co-Agent ID	
H7	M/I Other Amount Claimed Submitted Count	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
H8	M/I Other Amount Claimed Submitted Qualifier	
H9	M/I Other Amount Claimed Submitted	
HA	M/I Flat Sales Tax Amount Submitted	
HB	M/I Other Payer Amount Paid Count	
HC	M/I Other Payer Amount Paid Qualifier	Only value of 07 – Drug benefit accepted
HD	M/I Dispensing Status	
HE	M/I Percentage Sales Tax Rate Submitted	
HF	M/I Quantity Intended To Be Dispensed	
HG	M/I Days Supply Intended To Be Dispensed	
HN	M/I Patient E-Mail Address	
J9	M/I DUR Co-Agent ID Qualifier	
JE	M/I Percentage Sales Tax Basis Submitted	
K5	M/I Transaction Reference Number	
KE	M/I Coupon Type	
LD	Low Dose Alert	
LR	Underuse Precaution	
M1	Patient Not Covered In This Aid Category	
M2	Recipient Locked In	
M3	Host PA/MC error	
M4	Prescription/Service Reference Number/Time Limit Exceeded	
M5	Requires Manual Claim	
M6	Host Eligibility Error	
M7	Host Drug File Error	
M8	Host Provider File Error	
ME	M/I Coupon Number	
MG	M/I Other Payer BIN Number	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
MH	M/I Other Payer Processor Control Number	
MJ	M/I Other Payer Group ID	
MK	Non-Matched Other Payer BIN Number	
MM	Non-Matched Other Payer Processor Control Number	
MN	Non-Matched Other Payer Group ID	
MP	Non-Matched Other Payer Cardholder ID	
MR	Product Not On Formulary	
MS	More than 1 Cardholder Found – Narrow Search Criteria	
MT	M/I Patient Assignment Indicator (Direct Member Reimbursement Indicator)	
MU	M/I Benefit Stage Count	
MV	M/I Benefit Stage Qualifier	
MW	M/I Benefit Stage Amount	
MX	Benefit Stage Count Does Not Match Number Of Repetitions	
MY	M/I Address Count	
MZ	Error overflow	
N/A	No external reject code. Internal error code only.	
N1	No patient match found.	
N3	M/I Medicaid Paid Amount	
N4	M/I Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)	
N5	M/I Medicaid ID Number	Unique Medicaid ID assigned to the patient. May be same as cardholder ID
N6	M/I Medicaid Agency Number	
N7	Use Prior Authorization Code Provided During Transition Period	
N8	Use Prior Authorization Code Provided For Emergency Fill	
NA	M/I Address Qualifier	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
NB	M/I Client Name	
NC	M/I Discontinue Date Qualifier	
ND	M/I Discontinue Date	
NE	M/I Coupon Value Amount	
NF	M/I Easy Open Cap Indicator	
NG	M/I Effective Date	
NH	M/I Expiration Date	
NJ	M/I File Structure Type	
NK	M/I Inactive Prescription Indicator	
NM	M/I Label Directions	
NN	Transaction Rejected At Switch Or Intermediary	
NP	M/I Other Payer-Patient Responsibility Amount Qualifier	
NQ	M/I Other Payer-Patient Responsibility Amount	
NR	M/I Other Payer-Patient Responsibility Amount Count	
NU	M/I Other Payer Cardholder ID	
NV	M/I Delay Reason Code	
NW	M/I Most Recent Date Filled	
NX	M/I Submission Clarification Code Count	
NY	M/I Number Of Fills To-Date	
PØ	Non-zero Value Required for Vaccine Administration	
P1	Associated Prescription/Service Reference Number Not Found	
P2	Clinical Information Counter Out Of	
	Sequence	
P3	Compound Ingredient Component Cnt Not Match No. Repetitions	
P4	Coordination of Benefits/Other Payments Count Does Not Match Number of Repetitions'	
P5	Coupon Expired	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
P6	Date Of Service Prior To Date Of Birth	
P7	Diagnosis Code Count Does Not Match number Of Repetitions	
P8	DUR/PPS Code Counter Out Of Sequence	
P9	Field Is Non-Repeatable	
PA	PA Exhausted/Not Renewable	
PB	Invalid Transaction Count For This Transaction Code	
PC	M/I Request Claim Segment	
PD	M/I Request Clinical Segment	
PE	M/I Request COB/Other Payments Segment	
PF	M/I Request Compound Segment	
PG	M/I Request Coupon Segment	
PH	M/I Request DUR/PPS Segment	
PJ	M/I Request Insurance Segment	
PK	M/I Request Patient Segment	
PM	M/I Request Pharmacy Provider Segment	
PN	M/I Request Prescriber Segment	
PP	M/I Request Pricing Segment	
PQ	M/I Narrative Segment	
PR	M/I Request Prior Authorization Segment	
PS	M/I Request Transaction Header Segment	
PT	M/I Request Workers Compensation Segment	
PU	M/I Number Of Fills Remaining	
PV	Non-Matched Associated Prescription/Service Date	
PW	Non-Matched Employer ID	
PX	Non-Matched Other Payer ID	
PY	Non-Matched Unit Form/Route of Administration	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
PZ	Non-Matched Unit Of Measure To Product/Service ID	
RØ	Professional Service Code Required For Vaccine Incentive Fee	
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 Cd Invalid For Product/Service ID	
R5	Product ID Must Be Zero When Product/Service ID Qualifier Equals 06	
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 Formulae	
RA	PA Reversal Out Of Order	
RB	Multiple Partials Not Allowed	
RC	Different Drug Entity Between Partial And Completion	
RD	Mismatched Cardholder/Group ID-Partial To Completion	
RF	Improper Order Of 'Dispensing Status' Code On Partial Fill	
RG	M/I Associated Prescription/Service Reference Number On Completion Transaction	
RH	M/I Associated Prescription/Service Date On Completion Transaction	
RJ	Associated Partial Fill Transaction Not On File	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
RK	Partial Fill Transaction Not Supported	
RL	Transitional benefit/Resubmit Claim	
RM	Completion transaction Not Permitted With Same 'Date of Service' as Partial Transaction	
RN	Plan Limits Exceeded On Intended Partial Fill Field Limitations	
RP	Out Of Sequence 'P' Reversal On Partial Fill Transaction	
RQ	M/I Original Dispensed Date	
RR	M/I Patient ID Qualifier Count	
RS	M/I Associated Prescription/Service Date On Partial Transaction	
RT	M/I Associated Prescription/Service Reference Number On Partial Transaction	
RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment	
SØ	Accumulator Month Count Does Not Match Number of Repetitions	
S1	M/I Accumulator Year	
S2	M/I Transaction Identifier	
S3	M/I Accumulated Patient True Out Of Pocket Amount	
S4	M/I Accumulated Gross Covered Drug Cost Amount	
S5	M/I DateTime	
S6	M/I Accumulator Month	
S7	M/I Accumulator Month Count	
S8	Non-Matched Transaction Identifier	
S9	M/I Financial Information Reporting Transaction Header Segment	
SA	M/I Quantity Dispensed To Date	
SB	M/I Record Delimiter	
SC	M/I Remaining Quantity	
SD	M/I Sender Name	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
SE	M/I Procedure Modifier Code Count	
SF	Other Payer Amount Paid Count Does Not Match Number Of Repetitions	
SG	Submission Clarification Code Count Does Not Match Number of Repetitions	
SH	Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions	
SJ	M/I Total Number Of Sending And Receiving Pharmacy Records	
SK	M/I Transfer Flag	
SM	M/I Transfer Type	
SN	M/I Package Acquisition Cost	
SP	M/I Unique Record Identifier	
SQ	M/I Unique Record Identifier Qualifier	
SW	Accumulated Patient True Out of Pocket must be equal to or greater than zero	
TØ	Accumulator Month Count Exceeds Number of Occurrences Supported	
T1	Request Financial Segment Required For Financial Information Reporting	
T2	M/I Request Reference Segment	
T3	Out of Order DateTime	
T4	Duplicate DateTime	
TD	M/I Pharmacist Initials	
TF	M/I Technician Initials	
TG	Address Count Does Not Match Number Of Repetitions	
TH	Patient ID Qualifier Count Does Not Match Number Of Repetitions	
TJ	Prescriber ID Count Does Not Match Number Of Repetitions	
TK	Prescriber Specialty Count Does Not Match Number Of Repetitions	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
TM	Telephone Number Count Does Not Match Number Of Repetitions	
TN	Emergency Fill/Resubmit Claim	
TP	Level of Care Change/Resubmit Claim	
TQ	Dosage Exceeds Product Labeling Limit	
TR	M/I Billing Entity Type Indicator	
TS	M/I Pay To Qualifier	
TT	M/I Pay To ID	
TU	M/I Pay To Name	
TV	M/I Pay To Street Address	
TW	M/I Pay To City Address	
TX	M/I Pay to State/ Province Address	
TY	M/I Pay To Zip/Postal Zone	
TZ	M/I Generic Equivalent Product ID Qualifier	
UØ	M/I Sending Pharmacy ID	
U7	M/I Pharmacy Service Type	
UA	M/I Generic Equivalent Product ID	
UU	DAW Ø cannot be submitted on a multisource drug with available generics.	
UZ	Other Payer Coverage Type (338-5C) required on reversals to downstream payers. Resubmit reversal with this field.	
VØ	M/I Telephone Number Count	
VA	Pay To Qualifier Submitted Not Supported	
VB	Generic Equivalent Product ID Qualifier Submitted Not Supported	
VC	Pharmacy Service Type Submitted Not Supported	
VD	Eligibility Search Time Frame Exceeded	
VE	M/I Diagnosis Code Count	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
WØ	M/I Telephone Number Qualifier	
W5	M/I Bed	
W6	M/I Facility Unit	
W7	M/I Hours of Administration	
W8	M/I Room	
W9	Accumulated Gross Covered Drug Cost Amount Must Be Equal To Or Greater Than Zero	
WE	M/I Diagnosis Code Qualifier	
XØ	M/I Associated Prescription/Service Fill Number	
X1	Accumulated Patient True Out of Pocket exceeds maximum	
X2	Accumulated Gross Covered Drug Cost exceeds maximum	
X3	Out of order Accumulator Months	
X4	Accumulator Year not current or prior year	
X5	M/I Financial Information Reporting Request Insurance Segment	
X6	M/I Request Financial Segment	
X7	Financial Information Reporting Request Insurance Segment Required For Financial Reporting	
X8	Procedure Modifier Code Count Exceeds Number Of Occurrences Supported	
X9	Diagnosis Code Count Exceeds Number Of Occurrences Supported	
XE	M/I Clinical Information Counter	
XZ	M/I Associated Prescription/Service Reference Number Qualifier	
YØ	M/I Purchaser Last Name	
Y1	M/I Purchaser Street Address	
Y2	M/I Purchaser City Address	
Y3	M/I Purchaser State/Province Code	
Y4	M/I Purchaser Zip/Postal Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
Y5	M/I Purchaser Country Code	
Y6	M/I Time of Service	
Y7	M/I Associated Prescription/Service Provider ID Qualifier	
Y8	M/I Associated Prescription/Service Provider ID	
Y9	M/I Seller ID	
YA	Compound Ingredient Modifier Code Count Exceeds Number Of Occurrences Supported	
YB	Other Amount Claimed Submitted Count Exceeds Number Of Occurrences Supported	
YC	Other Payer Reject Count Exceeds Number Of Occurrences Supported	
YD	Other Payer-Patient Responsibility Amount Count Exceeds Number Of Occurrences Supported	
YE	Submission Clarification Code Count Exceeds Number of Occurrences Supported	
YF	Question Number/Letter Count Exceeds Number Of Occurrences Supported	
YG	Benefit Stage Count Exceeds Number Of Occurrences Supported	
YH	Clinical Information Counter Exceeds Number of Occurrences Supported	
YJ	Non-Matched Medicaid Agency Number	
YK	M/I Service Provider Name	
YM	M/I Service Provider Street Address	
YN	M/I Service Provider City Address	
YP	M/I Service Provider State/Province Code Address	
YQ	M/I Service Provider Zip/Postal Code	
YR	M/I Patient ID Associated State/Province Address	
YS	M/I Purchaser Relationship Code	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
YT	M/I Seller Initials	
YU	M/I Purchaser ID Qualifier	
YV	M/I Purchaser ID	
YW	M/I Purchaser ID Associated State/Province Code	
YX	M/I Purchaser Date of Birth	
YY	M/I Purchaser Gender Code	
YZ	M/I Purchaser First Name	
ZØ	Purchaser Country Code Not Supported For Processor/Payer	
Z1	Prescriber Alternate ID Qualifier Not Supported	
Z2	M/I Purchaser Segment	
Z3	Purchaser Segment Present On A Non-Controlled Substance Reporting Transaction	
Z4	Purchaser Segment Required On A Controlled Substance Reporting Transaction	
Z5	M/I Service Provider Segment	
Z6	Service Provider Segment Present On A non-Controlled Substance Reporting Transaction	
Z7	Service Provider Segment Required On A Controlled Substance Reporting Transaction	
Z8	Purchaser Relationship Code Not Supported	
Z9	Prescriber Alternate ID Not Covered	
ZB	M/I Seller ID Qualifier	
ZC	Associated Prescription/Service Provider ID Qualifier Value Not Supported For Processor/Payer	
ZD	Associated Prescription/Service Reference Number Qualifier Submitted Not Covered	
ZE	M/I Measurement Date	
ZF	M/I Sales Transaction ID	

NCPDP Reject Code	NCPDP Reject Code Description	Comments
ZK	M/I Prescriber ID Associated State/Province Address	
ZM	M/I Prescriber Alternate ID Qualifier	
ZN	Purchaser ID Qualifier Value Not Supported For Processor/Payer	
ZP	M/I Prescriber Alternate ID	
ZQ	M/I Prescriber Alternate ID Associated State/Province Address	
ZS	M/I Reported Payment Type	
ZT	M/I Released Date	
ZU	M/I Released Time	
ZV	Reported Payment Type Not Supported	
ZW	M/I Compound Preparation Time	
ZX	M/I CMS Part D Contract ID	
ZY	M/I Medicare Part D Plan Benefit Package (PBP)	
ZZ	Cardholder ID submitted is inactive. New Cardholder ID on file.	

Appendix G – Directory

Contact/Topic	Contact Numbers	Mailing, Email, and Web Addresses	Purpose/Comments
Pharmacy Support Center 24/7/365	1-877-624-5204 Fax: 1-888-603-7696 or 1-800-250-6950	Magellan Medicaid Administration, Inc. 11013 West Broad Street, Suite 500 Glen Allen, VA 23060	Pharmacy calls for • ProDUR questions • Nonclinical prior authorization and early refills • Overrides for the Beneficiary Lock-In Program • Questions regarding payer specifications Etc.
Clinical Support Center 7:00 a.m.–7:00 p.m. Monday–Friday (After hours calls rollover to Pharmacy Support Center)	1-877-864-9014 Fax: 1-888-603-7696 or 1-800-250-6950		Prescriber calls for • PA on non-preferred products • PA for other clinical reasons Etc. • Pharmacy calls for Dollar amount limits • Medicare Part B coinsurance, etc.
Beneficiary Inquiries 24/7/365	1-877-681-7540		To respond to inquiries on general pharmacy coverages, the MDHHS Beneficiary Help Line is available at 1-800-642-3195 for eligibility issues.
Provider Operations Department 8:15 a.m.–4:45 p.m. Monday–Friday MDHHS Pharmacy Enrollment	1-888-868-9219	Magellan Medicaid Administration, Inc. Provider Operations 11013 West Broad Street Suite 500 Glen Allen, VA 23060	• To request EFT payments • To request a paper copy of Pharmacy Claims Processing Manual • To enroll as an MDHHS pharmacy • Online provider enrollment is available by clicking the provider tab then Provider enrollment. A user ID and password is required. https://michigan.magellanrx.com/

Contact/Topic	Contact Numbers	Mailing, Email, and Web Addresses	Purpose/Comments
Electronic Media Claims Coordinator 8:00 a.m.–9:00 p.m. Monday–Friday (Except holidays)	1-800-924-6741 Fax: 1-804-273-6797	Electronic Media Claims (EMC) Magellan Medicaid Administration, Inc. Media Control/Michigan EMC Processing Unit 11013 West Broad Street Suite 500 Glen Allen, VA 23060 edivmap@magellanhealth.com	To ask questions on • FTP claims submission • Electronic remittance advices
Directory Assistance 8:00 a.m.–5:00 p.m. Monday–Friday	1-800-884-2822		To locate an employee at Magellan Medicaid Administration
Vendor Software Certification and Testing 8:00 a.m.–5:00 p.m. Monday–Friday		vendor_certification@magellanhealth.com	• To confirm a software's vendor certification • For software vendors, to obtain certification and test billing transaction sets
Universal Claim Forms (UCFs)	1-877-817-3676	CommuniForm 9240 East Raintree Drive Scottsdale, AZ 85260 https://www.asbaces.com/NEWACES/(S(5vdsnk11hgm3c1m314wvgcxt))/storefront.aspx	To obtain UCFs
NCPDP 7:00 a.m.–5:00 p.m. MT Monday–Friday	1-480-477-1000 **Fax:** 1-480-767-1043	National Council for Prescription Drug Programs 9240 East Raintree Drive Scottsdale, AZ 85260-7518 https://www.ncpdponline.org	To obtain a NCPDP # or update addresses

Web Addresses

Magellan Medicaid Administration	https://michigan.magellanrx.com/
MDHHS	www.michigan.gov/mdch To view the Michigan Medicaid Provider Manual, select Policy, Letters, and Forms. Refer to the *Directory Appendix* within the Michigan Medicaid Provider Manual for contact information and other useful MDHHS websites.

Mailing Addresses for Claims Submission

Paper Claims (UCFs)

Paper Claims Processing Unit
Michigan Medicaid
P.O. Box 9971
Glen Allen, VA 23060

Additional Phone Numbers

National Data Corporation (NDC)	WebMD	QS1
1-800-388-2316	1-615-885-3700	1-800-845-7558