EHO360, LLC. NCPDP Version d.0 Payer Sheet

Payer Name: EHO360, LLC.	Date: 01/01/2025	
Plan Name/Group Name: ALL PLANS	BIN: 004527	PCN:
Plan Name/Group Name: ALL PLANS	BIN: 003241	PCN:
Plan Name/Group Name: ALL Walgreen's Non-Workers' Comp Rxs	BIN: 004880	PCN:
Plan Name/Group Name: ALL TEST CLAIMS	BIN: 610259	PCN:
Processor: EHO		
Effective as of: 1/01/2025	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: Date of Publication	NCPDP External Code List Version Date:	
Contact/Information Source: Trent Lanham . trent@ehorx.com - (254) 771-6000		
Certification Testing Window: 01/01/2025 - forward		
Certification Contact Information: Certification Not Required		
Provider Relations Help Desk Info: (800) 650-1817		
Provider Relations Email Support: support@ehorx.com		

	Transaction Header Segment			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	(see above)	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	1	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M	NPI ONLY
2Ø1-B1	SERVICE PROVIDER ID	10 digit NPI number	M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		O	

	Insurance Segment **Segment Identification (111-AM) = "Ø4"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	
312-CC	CARDHOLDER FIRST NAME		M	
313-CD	CARDHOLDER LAST NAME		M	
314-CE	HOME PLAN		O	
524-FO	PLAN ID		O	
3Ø1-C1	GROUP ID		M	*Always required. Refer to Member ID Card.*
3Ø3-C3	PERSON CODE		S	*Varies by plan*
3Ø6-C6	PATIENT RELATIONSHIP CODE		S	*Varies by plan*
359-2A	MEDIGAP ID		O	
36Ø-2B	MEDICAID INDICATOR		O	
361-2D	PROVIDER ACCEPT ASSIGNMENT INDICATOR		O	
997-G2	CMS PART D DEFINED QUALIFIED FACILITY		O	
115-N5	MEDICAID ID NUMBER		O	

	Patient Segment **Segment Identification (111-AM) = "Ø1"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
331-CX	PATIENT ID QUALIFIER		R	
332-CY	PATIENT ID		R	
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE		R	
31Ø-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		O	
323-CN	PATIENT CITY ADDRESS		O	
324-CO	PATIENT STATE / PROVINCE ADDRESS		O	
325-CP	PATIENT ZIP/POSTAL ZONE		O	
326-CQ	PATIENT PHONE NUMBER		O	
3Ø7-C7	PLACE OF SERVICE		S	
333-CZ	EMPLOYER ID		O	
384-4X	PATIENT RESIDENCE		O	

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	Ø1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE		R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED		O	
419-DJ	PRESCRIPTION ORIGIN CODE		RW	*Varies by plan*
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	O	Required if Submission Clarification Code (42Ø-DK) is used.
42Ø-DK	SUBMISSION CLARIFICATION CODE		O	
3Ø8-C8	OTHER COVERAGE CODE		RW	Required for Coordination of Benefits.
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER		O	Required if Originally Prescribed Product/Service Code (455-EA) is used.
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE		O	
446-EB	ORIGINALLY PRESCRIBED QUANTITY		O	
418-DI	LEVEL OF SERVICE		O	
460-ET	QUANTITY PRESCRIBED		RW	Effective 09/21/20 : 460-ET is required when the transmission is for a Schedule II drug as defined in 21 CFR 1308.12 and per CMS-0055-F

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				(Compliance date 09/21/20).
461-EU	PRIOR AUTHORIZATION TYPE CODE		RW	*Varies by plan*
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	*Varies by plan*
995-E2	ROUTE OF ADMINISTRATION		O	
996-G1	COMPOUND TYPE		O	
147-U7	PHARMACY SERVICE TYPE		O	

	Prescriber Segment **Segment Identification (111-AM) = "Ø3"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER		M	
411-DB	PRESCRIBER ID		M	NPI should be submitted whenever possible
427-DR	PRESCRIBER LAST NAME		O	
498-PM	PRESCRIBER PHONE NUMBER		O	
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER		O	
421-DL	PRIMARY CARE PROVIDER ID		O	
47Ø-4E	PRIMARY CARE PROVIDER LAST NAME		O	
364-2J	PRESCRIBER FIRST NAME		O	
365-2K	PRESCRIBER STREET ADDRESS		O	
366-2M	PRESCRIBER CITY ADDRESS		O	
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS		O	
368-2P	PRESCRIBER ZIP/POSTAL ZONE		O	

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Situational*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	RM	
338-5C	OTHER PAYER COVERAGE TYPE		RM	
339-6C	OTHER PAYER ID QUALIFIER		R	Required if Other Payer ID (34Ø-7C) is used.
34Ø-7C	OTHER PAYER ID		R	Required if identification of the Other Payer is necessary for claim/encounter adjudication.
443-E8	OTHER PAYER DATE		R	Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	Required if Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER		RW	Required if Other Payer Amount Paid (431-DV) is used.
431-DV	OTHER PAYER AMOUNT PAID		M	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.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	Required if Other Payer Reject Code (472-6E)

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Situational*
				is used.
472-6E	OTHER PAYER REJECT CODE		RW	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).
	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing/Claim Rebill** Scenario 2- Other Payer-Patient Responsibility Amount Repetitions
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		O	*Imp Guide:* Required if Other Payer ID (34Ø-7C) is used.
34Ø-7C	OTHER PAYER ID		O	
443-E8	OTHER PAYER DATE		O	
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	O	*Imp Guide:* Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		O	*Imp Guide:* Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		O	*Imp Guide:* Required if necessary for patient financial responsibility only billing.

	Pricing Segment Segment Identification (111-AM) = "11"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*This segment is always sent*
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		R	
433-DX	PATIENT PAID AMOUNT SUBMITTED		O	
438-E3	INCENTIVE AMOUNT SUBMITTED		O	
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	S	Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		S	Required if Other Amount Claimed Submitted (48Ø-H9) is used.
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED		O	
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		O	
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		O	
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		S	*Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used.
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		S	*Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*This segment is always sent*
				Sales Tax Rate Submitted (483-HE) are used.
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		R	*Imp Guide:* Required if needed for receiver claim/encounter adjudication.

	Compound Segment **Segment Identification (111-AM) = "1Ø"**	**Optional Segment** **Required for Compounds**		**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		RW	Required when compound is being submitted.
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		RW	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	RW	
488-RE	COMPOUND PRODUCT ID QUALIFIER		RW	
489-TE	COMPOUND PRODUCT ID		RW	
448-ED	COMPOUND INGREDIENT QUANTITY		RW	
449-EE	COMPOUND INGREDIENT DRUG COST		RW	Required if needed for receiver claim determination when multiple products are billed.
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION		RW	*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed.
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Maximum count of 1Ø.	O	*Imp Guide:* Required when Compound Ingredient Modifier Code (363-2H) is sent.
363-2H	COMPOUND INGREDIENT MODIFIER CODE		O	

	Clinical Segment **Segment Identification (111-AM) = "13"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	O	*Imp Guide:* Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.
492-WE	DIAGNOSIS CODE QUALIFIER		O	*Imp Guide:* Required if Diagnosis Code (424-DO) is used.
424-DO	DIAGNOSIS CODE		O	

	Clinical Segment **Segment Identification (111-AM) = "13"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	O	*Imp Guide:* Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.
492-WE	DIAGNOSIS CODE QUALIFIER		O	*Imp Guide:* Required if Diagnosis Code (424-DO) is used.
424-DO	DIAGNOSIS CODE		O	

CLAIM BILLING/CLAIM REBILL PAID (OR DUPLICATE OF PAID) RESPONSE

	Response Transaction Header Segment			**Claim Billing/Claim Rebill – 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, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

	Response Message Segment Segment Identification (111-AM) = "2Ø"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		S	Imp Guide: Required if text is needed for clarification or detail.

	Response Insurance Segment Segment Identification (111-AM) = "25"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø1-C1	GROUP ID		R	
524-FO	PLAN ID		S	*Part-D* *Commercial*
545-DF	NETWORK REIMBURSEMENT ID	*Value*	RW	*Use: 36076513*
3Ø2-C2	CARDHOLDER ID		S	*Imp Guide:* Required if the identification to be used in future transactions is different than what was submitted on the request.

	Response Patient Segment Segment Identification (111-AM) = "29"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
31Ø-CA	PATIENT FIRST NAME		O	
311-CB	PATIENT LAST NAME		O	
3Ø4-C4	DATE OF BIRTH		O	

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill – 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		R	
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.	S	
548-6F	APPROVED MESSAGE CODE		S	
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	O	
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		O	
526-FQ	ADDITIONAL MESSAGE INFORMATION		O	
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		O	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	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	
551-9F	PREFERRED PRODUCT COUNT	Maximum count of 6.	S	*Future capabilities*
552-AP	PREFERRED PRODUCT ID QUALIFIER		S	*Future capabilities*
553-AR	PREFERRED PRODUCT ID		S	*Future capabilities*
554-AS	PREFERRED PRODUCT INCENTIVE		S	*Future capabilities*
555-AT	PREFERRED PRODUCT COST SHARE INCENTIVE		S	*Future capabilities*
556-AU	PREFERRED PRODUCT DESCRIPTION		S	*Future capabilities*

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø5-F5	PATIENT PAY AMOUNT		R	
5Ø6-F6	INGREDIENT COST PAID		R	
5Ø7-F7	DISPENSING FEE PAID		R	
558-AW	FLAT SALES TAX AMOUNT PAID		S	
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		S	
56Ø-AY	PERCENTAGE SALES TAX RATE PAID		S	*Imp Guide:* Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).
561-AZ	PERCENTAGE SALES TAX BASIS PAID		O	*Imp Guide:* Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).
521-FL	INCENTIVE AMOUNT PAID		S	Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø).
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	S	*Imp Guide:* Required if Other Amount Paid (565-J4) is used.
564-J3	OTHER AMOUNT PAID QUALIFIER		S	*Imp Guide:* Required if Other Amount Paid (565-J4) is used.
565-J4	OTHER AMOUNT PAID		S	Required if Other Amount Claimed Submitted (48Ø-H9) is greater than zero (Ø).
566-J5	OTHER PAYER AMOUNT RECOGNIZED		S	Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.
5Ø9-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		S	Required if Basis of Cost Determination (432-DN) is submitted on billing.
523-FN	AMOUNT ATTRIBUTED TO SALES TAX		S	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes sales tax that is the financial responsibility of the member but is not also included in any of the other fields that add up to Patient Pay Amount.
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT		S	
513-FD	REMAINING DEDUCTIBLE AMOUNT		S	
514-FE	REMAINING BENEFIT AMOUNT		S	
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		S	
518-FI	AMOUNT OF COPAY		S	
52Ø-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		S	
572-4U	AMOUNT OF COINSURANCE		S	

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	S	*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used.
393-MV	BENEFIT STAGE QUALIFIER		S	*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used.
394-MW	BENEFIT STAGE AMOUNT		S	*Imp Guide:* Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs.
577-G3	ESTIMATED GENERIC SAVINGS		S	
128-UC	SPENDING ACCOUNT AMOUNT REMAINING		S	
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION		S	
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG		S	
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION		S	
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION		S	
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP		S	

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"	**Situation Segment**		**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	S	
439-E4	REASON FOR SERVICE CODE		S	
528-FS	CLINICAL SIGNIFICANCE CODE		S	
529-FT	OTHER PHARMACY INDICATOR		S	
53Ø-FU	PREVIOUS DATE OF FILL		S	
531-FV	QUANTITY OF PREVIOUS FILL		S	
532-FW	DATABASE INDICATOR		S	
533-FX	OTHER PRESCRIBER INDICATOR		S	
544-FY	DUR FREE TEXT MESSAGE		S	
57Ø-NS	DUR ADDITIONAL TEXT		S	

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"	**Situation Segment**		**Claim Billing/Claim Rebill – 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		S	
34Ø-7C	OTHER PAYER ID		O	
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		O	
356-NU	OTHER PAYER CARDHOLDER ID		O	
992-MJ	OTHER PAYER GROUP ID		O	

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"	**Situation Segment**		**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
142-UV	OTHER PAYER PERSON CODE		O	
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		O	
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		O	
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		O	
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		O	

	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 = RxBilling	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	