

# WYOMING MEDICAID NCPDP VERSION D.Ø PAYER SHEET

## REQUEST CLAIM BILLING/CLAIM REBILL

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

### GENERAL INFORMATION

Payer Name: <b>Wyoming Department of Health</b>	Date: <b>October 20, 2021</b>
Plan Name/Group Name: <b>WYOPOP</b>	BIN: <b>Ø14293</b> PCN: <b>WYOPOP</b>
Processor: <b>Change Healthcare (CHC)</b>	
Effective as of: <b>September 10, 2021</b>	NCPDP Telecommunication Standard Version/Release #: <b>D.Ø</b>
NCPDP Data Dictionary Version Date: <b>July 2007</b>	NCPDP External Code List Version Date: <b>July 2013</b>
Contact/Information Source:	
Certification Testing Window:	
Certification Contact Information: <b>877-553-8455</b>	
Provider Relations Help Desk Info: <b>877-2Ø9-1264</b>	
Other versions supported:	

### OTHER TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name
B2	Claim Reversal

### FIELD LEGEND FOR COLUMNS

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

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

### CLAIM BILLING/CLAIM REBILL TRANSACTION

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

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

Field #	Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill Payer Situation
1Ø1-A1	BIN NUMBER	Ø14293	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	WYOPOP	M	
1Ø9-A9	TRANSACTION COUNT	Ø1- Ø4	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1=National Provider Identifier (NPI)	M	

Transaction Header Segment			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank Fill	M	

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

Insurance Segment Identification (111-AM) = "04"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID	Member ID as issued to the Medicaid Beneficiary	M	
301-C1	GROUP ID		RW	<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs. Required if needed for pharmacy claim processing and payment. <i>Payer Requirement:</i> WY Medicaid requires submission for utilization in subrogation
306-C6	PATIENT RELATIONSHIP CODE		RW	<i>Imp Guide:</i> Required if needed to uniquely identify the relationship of the Patient to the Cardholder. <i>Payer Requirement:</i> WY Medicaid requires submission for utilization in subrogation

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

Patient Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill	
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
304-C4	DATE OF BIRTH		R	
305-C5	PATIENT GENDER CODE		R	
310-CA	PATIENT FIRST NAME		RW	<i>Imp Guide:</i> Required when the patient has a first name. <i>Payer Requirement:</i> Required to be sent
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		RW	<i>Imp Guide:</i> Optional. <i>Payer Requirement:</i> WY Medicaid requires submission for utilization in subrogation
323-CN	PATIENT CITY ADDRESS		RW	<i>Imp Guide:</i> Optional. <i>Payer Requirement:</i> WY Medicaid requires submission for utilization in subrogation
325-CP	PATIENT ZIP/POSTAL ZONE		RW	<i>Imp Guide:</i> Optional.

				<i>Payer Requirement:</i> WY Medicaid requires submission for utilization in subrogation
307-C7	PLACE OF SERVICE		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> WY Medicaid requires submission for utilization in subrogation
335-2C	PREGNANCY INDICATOR	2=Pregnant	RW	<i>Imp Guide:</i> Required if pregnancy could result in different coverage, pricing, or patient financial responsibility.  Required if “required by law” as defined in the HIPAA final Privacy regulations section 164.501 definitions (45 CFR Parts 160 and 164 Standards for Privacy of Individually Identifiable Health Information; Final Rule-Thursday, December 28, 2000, page 82803 and following, and Wednesday, August 14, 2002, page 53267 and following.)  <i>Payer Requirement:</i> Required if needed to override copayment on a claim for a pregnant member.
384-4X	PATIENT RESIDENCE		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> WY Medicaid requires submission for utilization in subrogation

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent	X	
This payer supports partial fills		
This payer does not support partial fills	X	

	Claim Segment Segment Identification (111-AM) = “07”			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	<i>Imp Guide:</i> For Transaction Code of “B1”, in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	00=Compound 01=UPC 02=HRI 03=NDC	M	Use '00' only when submitting claims for compounded prescriptions, in all other instances use the qualifier appropriate for the product ID in field 407-D7
407-D7	PRODUCT/SERVICE ID		M	Use 0 only when submitting claims for compounded prescription claims, in all other instances use the ID of the product being dispensed.
442-E7	QUANTITY DISPENSED		R	
403-D3	FILL NUMBER	0=Original Dispensing 1 to 99 = Refill Number	R	

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	1=Not a Compound 2=Compound	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED	Ø=No Refills Authorized 1 through 99, with 99 being as needed, refills unlimited	RW	<i>Imp Guide:</i> Required if necessary for plan benefit administration.  <i>Payer Requirement:</i> Required when available on first fill.
419-DJ	PRESCRIPTION ORIGIN CODE	1=Written 2= Telephone 3=Electronic 4=Facsimile 5=Pharmacy	RW	<i>Imp Guide:</i> Required if necessary for plan benefit administration.  <i>Payer Requirement:</i> Same as Imp. Guide
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Submission Clarification Code (42Ø-DK) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
42Ø-DK	SUBMISSION CLARIFICATION CODE	Ø1=No Override Ø2= Other Override: First dose of a two-dose vaccine Ø4=Lost Prescription Ø5=Therapy Change Ø6=Starter Dose Ø7=Medically Necessary Ø8=Process Compound for Approved Ingredients 1Ø=Meets Plan Limitations	RW	<i>Imp Guide:</i> Required if clarification is needed and value submitted is greater than zero (Ø).  'Ø2'= Used when authorized by the payer in business cases not currently addressed by other SCC values.  'Ø4=Lost Prescription' and 'Ø5=Therapy Change' required when submitting early refill override  'Ø6'= The pharmacist is indicating that the previous medication was a starter dose and now additional medication is needed to continue treatment.  Ø7= The pharmacist is indicating that this medication has been determined by the physician to be medically necessary.  'Ø8=Process Compound for Approved Ingredients' required when submitting a claim for a compound that has non- approved or ingredients without an NDC number  1Ø= The pharmacy certified that the transaction is in compliance with the program's policies and rules that are specific to the particular product being billed.  <i>Payer Requirement:</i> Required when provider will accept payment on one or more, but not necessarily all, ingredients of a multi-ingredient compound and consider payment received as payment in full for the prescribed products

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				If the Date of Service (4Ø1-D1) contains the subsequent payer coverage date, the Submission Clarification Code (42Ø-DK) is required with value of "19" (Split Billing – indicates the quantity dispensed is the remainder billed to a subsequent payer when Medicare Part A expires. Used only in long-term care settings) for individual unit of use medications.
46Ø-ET	QUANTITY PRESCRIBED		RW	<i>Imp Guide:</i> Schedule II Drugs Prescribed
3Ø8-C8	OTHER COVERAGE CODE	Ø=Not specified 1=No other coverage 2=Other Coverage Exists payment collected 3=Other coverage billed – claim not covered 4= Other Coverage Exists payment not collected	RW	<i>Imp Guide:</i> 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.  <i>Payer Requirement:</i> Accepting 'Ø' when Other Coverage is not specified. Claims should be defaulted to this value if no other value is provided.  Accepting 1 to override prior claim rejection caused by other insurance being applicable as primary insurer in Wyoming Medicaid eligibility data, but other insurance is not in effect. <b>This value should not be the default value</b>  Accepting '3' for Part D excluded drugs  If a '3' is submitted, there should a minimum of 1 Other Payer Reject Code (472-6E) submitted and no Other Payer-Patient Responsibility Qualifier field (351-NP) submitted.
429-DT	SPECIAL PACKAGING INDICATOR	All Values Accepted	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> Use 3=Pharmacy Unit Dose for compensation of pharmacy-prepared unit dose packaging.
6ØØ-28	UNIT OF MEASURE		RW	<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.  Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> Required if submitting a compounded prescription claim and Compound Code (4Ø6-D6) = 2.
461-EU	PRIOR AUTHORIZATION TYPE CODE	Ø=Not Specified 2=Med Cert 3=EPDST	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.

	<b>Claim Segment Segment Identification (111-AM) = “07”</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
		4=Exemption from Copay and/or Colnsurance		Payer Requirement: Required if this field could result in different coverage, pricing, or patient financial responsibility.  '2=Med Cert' Required when submitting medical certification for pregnancy or emergency fill.  '3=EPDST' required when submitted Early Periodic Screening Diagnosis  '4=Exemption from Copay' required when submitting reason for exemption from copay
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	4 = Pregnant 6 = American Indian 8 = Emergency Supply	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  Payer Requirement: Required when submitting medical certification for pregnancy or emergency fill or a copay exemption for pregnancy, American Indian.
995-E2	ROUTE OF ADMINISTRATION		RW	<i>Imp Guide:</i> Required if specified in trading partner agreement.  <i>Payer Requirement:</i> Same as Imp. Guide

<b>Pricing Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	<b>Pricing Segment Segment Identification (111-AM) = “11”</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
409-D9	INGREDIENT COST SUBMITTED	340B pharmacies – submit 340B cost here with the Basis of Cost Determination (423-DN) indicator of '08=340B'	R	
430-DU	GROSS AMOUNT DUE		R	
412-DC	DISPENSING FEE SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (430-DU) calculation.  <i>Payer Requirement:</i> Same as Imp. Guide
433-DX	PATIENT PAID AMOUNT SUBMITTED		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> Same as Imp Guide
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (430-DU) calculation.

	<b>Pricing Segment Segment Identification (111-AM) = “11”</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				<i>Payer Requirement: Same as Imp Guide</i>
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW	<i>Imp Guide: Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.</i> <i>Payer Requirement: Same as Imp Guide</i>
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		RW	<i>Imp Guide: Required if Other Amount Claimed Submitted (480-H9) is used.</i> <i>Payer Requirement: Same as Imp Guide</i>
480-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	<i>Imp Guide: Required if its value has an effect on the Gross Amount Due (430-DU) calculation.</i> <i>Payer Requirement: Same as Imp Guide</i>
426-DQ	USUAL AND CUSTOMARY CHARGE		RW	<i>Imp Guide: Required if needed per trading partner agreement.</i> <i>Payer Requirement: Wyoming Medicaid agreements require submission of Usual and Customary Charge.</i>
423-DN	BASIS OF COST DETERMINATION	15= Free product or no associated cost	RW	<i>Imp Guide: Required if needed for receiver claim/encounter adjudication.</i> <i>Payer Requirement: Use indicator (08=340B) for 340B claims, with the amount being submitted in the Ingredient Cost Submitted (409-D9) field.</i>

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

	<b>Prescriber Segment Segment Identification (111-AM) = “03”</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
466-EZ	PRESCRIBER ID QUALIFIER	01=National Provider Identifier	RW	<i>Imp Guide: Required if Prescriber ID (411-DB) is used.</i> <i>Payer Requirement: Field should always be sent</i>
411-DB	PRESCRIBER ID	National Provider ID	RW	<i>Imp Guide: Required if this field could result in different coverage or patient financial responsibility.</i>  <i>Required if necessary for state/federal/regulatory agency programs.</i> <i>Payer Requirement: NPI of prescriber is required.</i>
427-DR	PRESCRIBER LAST NAME		RW	<i>Imp Guide: Required when the Prescriber ID (411-DB) is not known. Required if</i>

	<b>Prescriber Segment Segment Identification (111-AM) = “Ø3”</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				needed for Prescriber ID (411-DB) validation/clarification.  <i>Payer Requirement: Required for Prescriber ID (411-DB) validation.</i>

<b>Coordination of Benefits/Other Payments Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill If Situational, Payer Situation</b>
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	X	

	<b>Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = “Ø5”</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
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	Ø1=National Payer ID Ø3=BIN	RW	<i>Imp Guide:</i> Required if Other Payer ID (34Ø-7C) is used.  <i>Payer Requirement:</i> Submit qualifier appropriate to the value submitted in Other Payer ID (34Ø-7C).
34Ø-7C	OTHER PAYER ID		RW	<i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication.  <i>Payer Requirement:</i> Submit National Payer ID (also referenced as “HPID”) of the primary payer when available, otherwise the BIN of the primary payer is required.
443-E8	OTHER PAYER DATE		RW	<i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.  <i>Payer Requirement:</i> Payment or denial date of the claim submitted to the other payer.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used.  <i>Payer Requirement:</i> Same as Imp Guide
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Only Ø7= Drug Benefit	RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used.



	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				<i>Payer Requirement: Same as Imp Guide</i>
431-DV	OTHER PAYER AMOUNT PAID		RW	<i>Imp Guide:</i> 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.  <i>Payer Requirement:</i> Required if other payer has returned a paid response. If OCC=2 (3Ø8-C8), value > Ø.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used.  <i>Payer Requirement:</i> Same as Imp Guide
472-6E	OTHER PAYER REJECT CODE		RW	<i>Imp Guide:</i> 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).  <i>Payer Requirement:</i> Submit as many reject codes as were returned by the other payer, up to the maximum identified in Other Payer Reject Count (471-5E)
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.  <i>Payer Requirement:</i> Same as Imp Guide
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø6=Patient Pay Amount	RW	<i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.  <i>Payer Requirement:</i> Required if Other Coverage Code (3Ø8-C8) = 2 or 4.  Wyoming Medicaid only accepts the Ø6=Patient Pay Amount.  Components of Patient Pay (Ø1-Ø5, Ø7-13) submitted will result in claim rejection.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	<i>Imp Guide:</i> 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.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"			Claim Billing/Claim Rebill	
				Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				<i>Payer Requirement:</i> Required if Other Coverage Code (308-C8) = 2 or 4 Required to identify components of patient responsibility amount assigned by other payer as indicated in the other payer's claim response

DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	Required if there is DUR information being sent.

DUR/PPS Segment Segment Identification (111-AM) = "08"			Claim Billing/Claim Rebill	
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	<i>Imp Guide:</i> Required if DUR/PPS Segment is used.  <i>Payer Requirement:</i> Same as Imp. Guide
439-E4	REASON FOR SERVICE CODE	DD – Drug-Drug Interaction TD – Therapeutic Duplication	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement:</i> Required if 441-E6 submitted.
440-E5	PROFESSIONAL SERVICE CODE		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement:</i> Required if 441-E6 submitted. All NCPDP values accepted, except 'ZZ'.
441-E6	RESULT OF SERVICE CODE		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				<i>Payer Requirement:</i> Required to override a DUR conflict. All NCPDP values accepted, except 'ØØ'. Corresponding 439-E4 and 44Ø-E5 required if 441-E6 sent.
474-8E	DUR/PPS LEVEL OF EFFORT		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement:</i> Same as Imp. Guide
475-J9	DUR CO-AGENT ID QUALIFIER		RW	<i>Imp Guide:</i> Required if DUR Co-Agent ID (476-H6) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
476-H6	DUR CO-AGENT ID		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement:</i> Same as Imp. Guide

Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	Required when the pharmacy is dispensing a compound of multiple ingredients and requesting payment for the prescribed compound from Wyoming Medicaid

	Compound Segment Segment Identification (111-AM) = "1Ø"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø1=UPC Ø2=HRI Ø3=NDC	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		RW	<i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed.

Compound Segment Segment Identification (111-AM) = "10"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				<i>Payer Requirement:</i> Required for each individual ingredient. Value may be Ø or greater but may not be left blank (NULL).
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION		RW	<i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed.  <i>Payer Requirement:</i> Required when a value is submitted in Compound Ingredient Drug Cost (449-EE)

Clinical Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Segment required to capture necessary information for Subrogation

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.	RW	<i>Imp Guide:</i> Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.  <i>Payer Requirement:</i> Same as Imp. Guide
492-WE	DIAGNOSIS CODE QUALIFIER		RW	<i>Imp Guide:</i> Required if Diagnosis Code (424-DO) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
424-DO	DIAGNOSIS CODE		RW	<i>Imp Guide:</i> 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.  <i>Payer Requirement:</i> WY Medicaid requires submission for utilization in subrogation

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

# RESPONSE CLAIM BILLING/CLAIM REBILL PAYER SHEET

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

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

### GENERAL INFORMATION

Payer Name: <b>Wyoming Department of Health</b>	Date: <b>October 20, 2021</b>	
Plan Name/Group Name: <b>Wyoming Medicaid</b>	BIN: <b>014293</b>	PCN: <b>WYOPOP</b>

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

The following lists the segments and fields in a Claim Billing or Claim Rebill response (Paid or Duplicate of Paid) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

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

	Response Transaction Header Segment			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) <i>Payer Situation</i>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Return when needed for transmission level messaging.</i>

	Response Message Segment Identification (111-AM) = "20"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) <i>Payer Situation</i>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> Will be returned when text information needs to be sent.

Response Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
This Segment is situational		

	<b>Response Insurance Segment Segment Identification (111-AM) = "25"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø1-C1	GROUP ID		RW	<i>Imp Guide:</i> 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 coverage's exist.  <i>Payer Requirement:</i> Same as Imp. Guide
568-J7	PAYER ID QUALIFIER		RW	<i>Imp Guide:</i> Required if Payer ID (569-J8) is used.  <i>Payer Requirement:</i> Will be returned
569-J8	PAYER ID		RW	<i>Imp Guide:</i> Required to identify the ID of the payer responding.  <i>Payer Requirement:</i> Will be returned
3Ø2-C2	CARDHOLDER ID		RW	<i>Imp Guide:</i> Required if the identification to be used in future transactions is different than what was submitted on the request.  <i>Payer Requirement:</i> Same as Imp. Guide

<b>Response Status Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	<i>Imp Guide:</i> Required if needed to identify the transaction.  <i>Payer Requirement:</i> Will be returned
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp. Guide

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp. Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> 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.  <i>Payer Requirement:</i> Same as Imp. Guide
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3=Processor/ PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used.  <i>Payer Requirement:</i> Will be returned
55Ø-8F	HELP DESK PHONE NUMBER	877-2Ø9-1264	RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.  <i>Payer Requirement:</i> Will be returned

<b>Response Claim Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i></b>
This Segment is always sent	X	

	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	<i>Imp Guide:</i> 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	

<b>Response Pricing Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i></b>
This Segment is always sent	X	

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
5Ø5-F5	PATIENT PAY AMOUNT	Reflects the Medicaid Copay amount	R	
5Ø6-F6	INGREDIENT COST PAID		R	

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
507-F7	DISPENSING FEE PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.  <i>Payer Requirement:</i> Same as Imp. Guide
521-FL	INCENTIVE AMOUNT PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.  Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø).  <i>Payer Requirement:</i> Same as Imp. Guide
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
564-J3	OTHER AMOUNT PAID QUALIFIER		RW	<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
565-J4	OTHER AMOUNT PAID		RW	<i>Imp Guide:</i> 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).  <i>Payer Requirement:</i> Same as Imp Guide, but will never be greater than Ø.
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	<i>Imp Guide:</i> 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.  <i>Payer Requirement:</i> Same as Imp. Guide
509-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		RW	<i>Imp Guide:</i> Required if Ingredient Cost Paid (506-F6) is greater than zero (Ø).  Required if Basis of Cost Determination (432-DN) is submitted on billing.  <i>Payer Requirement:</i> Return 14 = Other Payer-Patient Responsibility Amount to Indicate reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ)



	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
523-FN	AMOUNT ATTRIBUTED TO SALES TAX		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-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.  <i>Payer Requirement:</i> Same as Imp Guide
513-FD	REMAINING DEDUCTIBLE AMOUNT		RW	<i>Imp Guide:</i> Provided for informational purposes only.  <i>Payer Requirement:</i> Same as Imp. Guide
514-FE	REMAINING BENEFIT AMOUNT		RW	<i>Imp Guide:</i> Provided for informational purposes only.  <i>Payer Requirement:</i> Same as Imp. Guide
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes deductible  <i>Payer Requirement:</i> Same as Imp Guide
518-FI	AMOUNT OF COPAY		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes copay as patient financial responsibility.  <i>Payer Requirement:</i> Same as Imp. Guide
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes amount exceeding periodic benefit maximum.  <i>Payer Requirement:</i> Same as Imp Guide
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE		RW	<i>Imp Guide:</i> Required if the customer is responsible for 100% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay.  <i>Payer Requirement:</i> Same as Imp Guide
572-4U	AMOUNT OF COINSURANCE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes coinsurance as patient financial responsibility.  <i>Payer Requirement:</i> Same as Imp. Guide

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT		RW	<i>Imp Guide:</i> Required when the patient meets the plan-funded assistance criteria, to reduce Patient Pay Amount (5Ø5-F5). The resulting Patient Pay Amount (5Ø5-F5) must be greater than or equal to zero.  <i>Payer Requirement:</i> Same as Imp Guide
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another  <i>Payer Requirement:</i> Same as Imp Guide
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand drug.  <i>Payer Requirement:</i> Same as Imp Guide
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON- PREFERRED FORMULARY SELECTION		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a non-preferred formulary product.  <i>Payer Requirement:</i> Same as Imp Guide
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand non-preferred formulary product.  <i>Payer Requirement:</i> Same as Imp Guide
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP		RW	<i>Imp Guide:</i> Required when the patient's financial responsibility is due to the coverage gap.  <i>Payer Requirement:</i> Same as Imp Guide

<b>Response DUR/PPS Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i></b>
This Segment is always sent		
This Segment is situational	X	Required if DUR information needs to be sent

	<b>Response DUR/PPS Segment Segment Identification (111-AM) = "24"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used.  <i>Payer Requirement:</i> Same as Imp Guide
439-E4	REASON FOR SERVICE CODE	DD – Drug-Drug Interaction TD – Therapeutic Duplication	RW	<i>Imp Guide:</i> Required if utilization conflict is detected.  <i>Payer Requirement:</i> Same as Imp Guide
528-FS	CLINICAL SIGNIFICANCE CODE		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide
529-FT	OTHER PHARMACY INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide.
530-FU	PREVIOUS DATE OF FILL		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  Required if Quantity of Previous Fill (531- FV) is used.  <i>Payer Requirement:</i> Same as Imp Guide.
531-FV	QUANTITY OF PREVIOUS FILL		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  Required if Previous Date Of Fill (530- FU) is used.  <i>Payer Requirement:</i> Same as Imp Guide.
532-FW	DATABASE INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide.
533-FX	OTHER PRESCRIBER INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide.
544-FY	DUR FREE TEXT MESSAGE		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide.

## CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

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

Field #	Response Transaction Header Segment <i>NCPDP Field Name</i>	Value	Payer Usage	Claim Billing/Claim Rebill Accepted/Rejected <i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	Returned when needed for transmission level messaging

Field #	Response Message Segment Segment Identification (111-AM) = "20"	Value	Payer Usage	Claim Billing/Claim Rebill Accepted/Rejected <i>Payer Situation</i>
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> Will be returned when text information needs to be sent.

Response Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

Field #	Response Insurance Segment Segment Identification (111-AM) = "25"	Value	Payer Usage	Claim Billing/Claim Rebill Accepted/Rejected <i>Payer Situation</i>
301-C1	GROUP ID		RW	<i>Imp Guide:</i> 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 coverage exist.  <i>Payer Requirement:</i> Same as Imp. Guide
568-J7	PAYER ID QUALIFIER		RW	<i>Imp Guide:</i> Required if Payer ID (569-J8) is used.  <i>Payer Requirement:</i> Will be returned
569-J8	PAYER ID		RW	<i>Imp Guide:</i> Required to identify the ID of the payer responding.  <i>Payer Requirement:</i> Will be returned

	<b>Response Insurance Segment Segment Identification (111-AM) = "25"</b>			<b>Claim Billing/Claim Rebill Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
302-C2	CARDHOLDER ID		RW	<i>Imp Guide:</i> Required if the identification to be used in future transactions is different than what was submitted on the request.  <i>Payer Requirement:</i> Same as Imp. Guide

<b>Response Status Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Rejected</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

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

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Billing/Claim Rebill Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3=Processor/ PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used.  <i>Payer Requirement:</i> Will be returned
55Ø-8F	HELP DESK PHONE NUMBER	877-2Ø9-1264	RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.  <i>Payer Requirement:</i> Will be returned

<b>Response Claim Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation</b>
This Segment is always sent	X	

	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Billing/Claim Rebill Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	<i>Imp Guide:</i> 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.	RW	<i>Imp Guide:</i> Required if Preferred Product ID (553-AR) is used.  <i>Payer Requirement:</i> Same as Imp. Guide

<b>Response DUR/PPS Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation</b>
This Segment is situational	X	Required if DUR information needs to be sent

	<b>Response DUR/PPS Segment Segment Identification (111-AM) = "24"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used.  <i>Payer Requirement:</i> Same as Imp Guide.
439-E4	REASON FOR SERVICE CODE	DD – Drug-Drug Interaction TD – Therapeutic Duplication	RW	<i>Imp Guide:</i> Required if utilization conflict is detected.  <i>Payer Requirement:</i> Same as Imp Guide.
528-FS	CLINICAL SIGNIFICANCE CODE		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide.

	<b>Response DUR/PPS Segment Identification (111-AM) = "24"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
529-FT	OTHER PHARMACY INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide.
530-FU	PREVIOUS DATE OF FILL		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  Required if Quantity of Previous Fill (531-FV) is used.  <i>Payer Requirement:</i> Same as Imp Guide.
531-FV	QUANTITY OF PREVIOUS FILL		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  Required if Previous Date Of Fill (530-FU) is used.  <i>Payer Requirement:</i> Same as Imp Guide.
532-FW	DATABASE INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide.
533-FX	OTHER PRESCRIBER INDICATOR		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide.
544-FY	DUR FREE TEXT MESSAGE		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict.  <i>Payer Requirement:</i> Same as Imp Guide.

### CLAIM BILLING/CLAIM REBILL REJECTED/REJECTED RESPONSE

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

	<b>Response Transaction Header Segment</b>			<b>Claim Billing/Claim Rebill Rejected/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	R = Rejected	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	Returned when needed for transmission level messaging

	Response Message Segment Segment Identification (111-AM) = "20"			Claim Billing/Claim Rebill Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> Will be returned when text information needs to be sent

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

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



	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Billing/Claim Rebill Rejected/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> 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.  <i>Payer Requirement:</i> Same as Imp. Guide
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3=Processor/ PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used.  <i>Payer Requirement:</i> Will be returned
55Ø-8F	HELP DESK PHONE NUMBER	877-2Ø9-1264	RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.  <i>Payer Requirement:</i> Will be returned

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

# WYOMING MEDICAID NCPDP VERSION D.Ø CLAIM REVERSAL PAYER SHEET

## REQUEST CLAIM REVERSAL

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

### GENERAL INFORMATION

Payer Name: Wyoming Department of Health	Date: October 20, 2021
Plan Name/Group Name: Wyoming Medicaid	BIN: Ø14293 PCN: WYOPOP

### 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

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	Wyoming Medicaid will accept reversal/resubmission within 12 months of date of service on the claim

### 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 Not used	X	

Field #	Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Reversal Payer Situation
1Ø1-A1	BIN NUMBER	Ø14293	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	WYOPOP	M	
1Ø9-A9	TRANSACTION COUNT	Ø1-Ø4	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1=National Provider Identifier	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	

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) = "04"				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	
301-C1	GROUP ID		RW	<i>Imp Guide:</i> Required if needed to match the reversal to the original billing transaction.  <i>Payer Requirement:</i> Same as Imp. Guide

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

Claim Segment Segment Identification (111-AM) = "07"				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	01 = Rx Billing	M	<i>Imp Guide:</i> For Transaction Code of "B2", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	00 – For compound submissions 01 – Universal Product Code (UPC) 02 – Health Related Item (HRI) 03 – National Drug Code (NDC)	M	
407-D7	PRODUCT/SERVICE ID		M	

**\*\* 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: <b>Wyoming Department of Health</b>	Date: <b>October 20, 2021</b>	
Plan Name/Group Name: <b>Wyoming Medicaid</b>	BIN: <b>Ø14293</b>	PCN: <b>WYOPOP</b>

### 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 <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

Field #	Response Transaction Header Segment	Value	Payer Usage	Claim Reversal – Accepted/Approved <i>Payer Situation</i>
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

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

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

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

Field #	Response Status Segment Identification (111-AM) = "21"	Value	Payer Usage	Claim Reversal – Accepted/Approved <i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	<i>Imp Guide:</i> Required if needed to identify the transaction.  <i>Payer Requirement:</i> 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
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.	RW	<i>Imp Guide:</i> Required if Approved Message Code (548-6F) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
548-6F	APPROVED MESSAGE CODE		RW	<i>Imp Guide:</i> Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity.  <i>Payer Requirement:</i> Same as Imp. Guide
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp. Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> 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.  <i>Payer Requirement:</i> Same as Imp. Guide
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03=Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used.  <i>Payer Requirement:</i> Will be returned
550-8F	HELP DESK PHONE NUMBER	877-209-1264	RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.  <i>Payer Requirement:</i> Will be returned

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 = RxBilling	M	<i>Imp Guide:</i> For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

### 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
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-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	Returned when needed for transmission level messaging

	Response Message Segment Segment Identification (111-AM) = "20"			Claim Reversal – Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> Will be returned when text information needs to be sent.

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	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Reversal – Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usag e</i>	<i>Payer Situation</i>
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence.  <i>Payer Requirement:</i> Same as Imp. Guide
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp. Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> 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.  <i>Payer Requirement:</i> Same as Imp. Guide
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03=Processor/ PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
550-8F	HELP DESK PHONE NUMBER	877-209-1264	RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.  <i>Payer Requirement:</i> Same as Imp. Guide

<b>Response Claim Segment Questions</b>	<b>Check</b>	<b>Claim Reversal - Accepted/Rejected</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

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

## CLAIM REVERSAL REJECTED/REJECTED RESPONSE

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

	Response Transaction Header Segment			Claim Reversal – Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B2	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Reversal – Rejected/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational		

	Response Message Segment Segment Identification (111-AM) = “20”			Claim Reversal – Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	MESSAGE		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail.  <i>Payer Requirement:</i> Will be returned when text information needs to be sent.

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

	Response Status Segment Segment Identification (111-AM) = “21”			Claim Reversal – Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence.  <i>Payer Requirement:</i> Same as Imp. Guide
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp. Guide



	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Reversal – Rejected/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp. Guide
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp. Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> 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.  <i>Payer Requirement:</i> Same as Imp. Guide
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3=Processor/ PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used.  <i>Payer Requirement:</i> Will be returned
55Ø-8F	HELP DESK PHONE NUMBER	877-2Ø9-1264	RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.  <i>Payer Requirement:</i> Will be returned

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