

## IOWA MEDICAID NCPDP VERSION D.Ø PAYER SHEET REQUEST CLAIM BILLING/CLAIM REBILL PAYER SHEET

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

### GENERAL INFORMATION

Payer Name: <b>Iowa Medicaid Enterprise</b>		Date: <b>December 16, 2011</b>
Plan Name/Group Name: <b>Iowa Medicaid</b>		BIN: <b>Ø11933</b> PCN: <b>IAPOP</b>
Processor: <b>IME POS Unit (GHS)</b>		
Effective as of: <b>11/28/2Ø11</b>		NCPDP Telecommunication Standard Version/Release #: <b>D.Ø</b>
NCPDP Data Dictionary Version Date: <b>July 2ØØ7</b>		NCPDP External Code List Version Date: <b>March 2Ø1Ø</b>
Contact/Information Source: <b>1-877-463-7671, 1-515-725-11Ø7(local)</b>		
Certification Testing Window:		
Certification Contact Information: <b>1-877-553-8455 POS Tech Support</b>		
Provider Relations Help Desk Info: <b>1-877-463-7671, 1-515-725-11Ø7(local)</b>		
Other versions supported: <b>NCPDP Telecommunication Standard v5.1 until 12/31/2Ø11</b>		

### OTHER TRANSACTIONS SUPPORTED

Transaction Code	Transaction Name
<b>B2</b>	<b>Claim Reversal</b>

### 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 <i>If Situational, Payer Situation</i>
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 <i>NCPDP Field Name</i>	Value	Payer Usage	Claim Billing/Claim Rebill <i>Payer Situation</i>
1Ø1-A1	BIN NUMBER	<b>Ø11933</b>	M	BIN for Iowa Medicaid
1Ø2-A2	VERSION/RELEASE NUMBER	<b>DØ</b>	M	
1Ø3-A3	TRANSACTION CODE	<b>B1, B3</b>	M	B1 – Claim billing B3 – Claim rebill
1Ø4-A4	PROCESSOR CONTROL NUMBER	<b>IAPOP</b>	M	
1Ø9-A9	TRANSACTION COUNT	<b>Ø1 – Ø4</b>	M	Ø1=One Occurrence Ø2=Two Occurrences Ø3=Three Occurrences Ø4= Four Occurrences
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	<b>Ø1=National Provider Identifier (NPI)</b>	M	Only the National Provider ID (NPI) is supported

Transaction Header Segment			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
201-B1	SERVICE PROVIDER ID		M	NPI of the submitting pharmacy
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	No other values required

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

Insurance Segment Segment Identification (111-AM) = "04"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	Member ID as issued to the Medicaid beneficiary
309-C9	ELIGIBILITY CLARIFICATION CODE		RW	<p><i>Imp Guide:</i> Required if needed for receiver inquiry validation and/or determination, when eligibility is not maintained at the dependent level. Required in special situations as defined by the code to clarify the eligibility of an individual, which may extend coverage.</p> <p><i>Payer Requirement:</i> Required if needed to clarify eligibility status in order to support claim approval.</p>
301-C1	GROUP ID		RW	<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.</p> <p>Required if needed for pharmacy claim processing and payment.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>

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

Patient Segment 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	<p><i>Imp Guide:</i> Required when the patient has a first name.</p> <p><i>Payer Requirement:</i> Required to be sent.</p>
311-CB	PATIENT LAST NAME		R	
326-CQ	PATIENT PHONE NUMBER		RW	<p><i>Imp Guide:</i> Optional.</p> <p><i>Payer Requirement:</i> Required if available.</p>
307-C7	PLACE OF SERVICE		RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

	Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
335-2C	PREGNANCY INDICATOR		RW	<p><i>Imp Guide:</i> Required if pregnancy could result in different coverage, pricing, or patient financial responsibility.</p> <p>Required if "required by law" as defined in the HIPAA final Privacy regulations section 164.5Ø1 definitions (45 CFR Parts 16Ø and 164 Standards for Privacy of Individually Identifiable Health Information; Final Rule-Thursday, December 28, 2ØØØ, page 828Ø3 and following, and Wednesday, August 14, 2ØØ2, page 53267 and following.)</p> <p><i>Payer Requirement:</i> <b>Required when known.</b></p>
35Ø-HN	PATIENT E-MAIL ADDRESS		RW	<p><i>Imp Guide:</i> May be submitted for the receiver to relay patient health care communications via the Internet when provided by the patient.</p> <p><i>Payer Requirement:</i> <b>Required if valid email address is available and known to the submitting pharmacy.</b></p>

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
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) = "Ø7"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	<p>Claim Billing</p> <p><i>Imp Guide:</i> For Transaction Code of "B1" or "B3", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing)</p>
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	<p>ØØ – For compound submissions</p> <p>Ø1 – Universal Product Code (UPC)</p> <p>Ø2 – Health Related Item (HRI)</p> <p>Ø3 – National Drug Code (NDC)</p>	M	<p><b>Use ØØ only when submitting claims for compounded prescription claims, in all other instances use the qualifier appropriate for the product ID in field 4Ø7-D7.</b></p>
4Ø7-D7	PRODUCT/SERVICE ID		M	<p><b>Use Ø only when submitting claims for compounded prescription claims, in all other instances use the ID of the product being dispensed.</b></p>
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER	<p>Ø=Original Dispensing</p> <p>1 to 99=Refill Number</p>	R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	<p>1=Not a Compound</p> <p>2=Compound</p>	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED	<p>Ø=No Refills Authorized</p> <p>1 through 99, with 99 being as needed, refills unlimited</p>	RW	<p><i>Imp Guide:</i> Required if necessary for plan benefit administration.</p> <p><i>Payer Requirement:</i> <b>Required when available on first fill.</b></p>

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
419-DJ	PRESCRIPTION ORIGIN CODE		RW	<i>Imp Guide:</i> Required if necessary for plan benefit administration.  <i>Payer Requirement:</i> <b>Required if known.</b>
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> <b>Same as implementation guide</b>
42Ø-DK	SUBMISSION CLARIFICATION CODE		RW	<i>Imp Guide:</i> Required if clarification is needed and value submitted is greater than zero (Ø).  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.  <i>Payer Requirement:</i> <b>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.</b>
3Ø8-C8	OTHER COVERAGE CODE	0=Not specified 1=No other coverage 3=Other coverage billed – claim not covered 8=Claim is billing for patient financial responsibility only	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> <b>Accepting '0' when Other Coverage is not specified. Claims should be defaulted to this value if no other value is provided.</b>  <b>Accepting 1 to override prior claim rejection caused by other insurance being applicable as primary insurer in Iowa Medicaid eligibility data, but other insurance is not in effect. This value should not be the default value</b>  <b>Accepting 3 for Part D excluded drugs</b>  <b>If a '03' 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.</b>  <b>If Ø8 is submitted, Other Payer-Patient Resp. Amount (352-NQ) with applicable qualifiers must be submitted.</b>
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> <b>Use 3=Pharmacy Unit Dose for compensation of pharmacy-prepared unit dose packaging. (Nursing Home)</b>

Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	Ø1 – Universal Product Code (UPC) Ø2 – Health Related Item (HRI) Ø3 – National Drug Code (NDC)	RW	<i>Imp Guide:</i> Required if Originally Prescribed Product/Service Code (445-EA) is used.  <i>Payer Requirement:</i> Same as Imp Guide
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE		RW	<i>Imp Guide:</i> Required if the receiver requests association to a therapeutic, or a preferred product substitution, or when a DUR alert has been resolved by changing medications, or an alternative service than what was originally prescribed.  <i>Payer Requirement:</i> Required if pharmacy has substituted a product for that which was originally prescribed. The product code should be one that is representative of what might have been submitted if substitution was not made.
446-EB	ORIGINALLY PRESCRIBED QUANTITY		RW	<i>Imp Guide:</i> Required if the receiver requests reporting for quantity changes due to a therapeutic substitution that has occurred or a preferred product/service substitution that has occurred, or when a DUR alert has been resolved by changing quantities.  <i>Payer Requirement:</i> Required if pharmacy has substituted a quantity for that which was originally prescribed.
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> Recommended to submit if compounded prescription claim and Compound Code (4Ø6-D6) = 2.
461-EU	PRIOR AUTHORIZATION TYPE CODE		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> 'Ø1'=Prior Auth requires a valid PA Number Submitted (462-EV); 'Ø2' = Med Cert and requires a clarifying State defined value in PA Number Submitted (462-EV) 'Ø8'=Payer Defined Exempt requires a '1' in PA Number Submitted (462-EV)
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Submit PA Number for the Med Cert and Payer Defined situations identified in 461-EU :  1 = 72 hour supply 4 = Pregnant 5 = NF Vaccine 7 = Mental Health Drugs	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> Submit the value provided by IME staff when needed to override standard rules of coverage, pricing and/or patient financial responsibility.
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

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

Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	INGREDIENT COST SUBMITTED		R	340B pharmacies – submit 340B cost here with the Basis of Cost Determination (423-DN) indicator of '08=340B'
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: Same as Imp Guide.</i>
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: Same as Imp Guide.</i>
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. <i>Payer Requirement: Same as Imp Guide.</i>
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted Qualifier (479-H8) is used. <i>Payer Requirement: Same as Imp Guide.</i>
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		RW	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted (480-H9) is used. <i>Payer Requirement: Same as Imp Guide.</i>
480-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (430-DU) calculation. <i>Payer Requirement: Same as Imp Guide.</i>
426-DQ	USUAL AND CUSTOMARY CHARGE		RW	<i>Imp Guide:</i> Required if needed per trading partner agreement. <i>Payer Requirement: Iowa Medicaid agreements require submission of Usual and Customary Charge.</i>
423-DN	BASIS OF COST DETERMINATION		RW	<i>Imp Guide:</i> Required if needed for receiver claim/encounter adjudication. <i>Payer Requirement: Use indicator (08=340B) for 340B claims, with the amount being submitted in the Ingredient Cost Submitted (409-D9) field.</i>

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

Prescriber Segment Segment Identification (111-AM) = "03"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	01 = National Provider Identifier (NPI)	RW	<i>Imp Guide:</i> Required if Prescriber ID (411-DB) is used. <i>Payer Requirement: Same as Imp Guide.</i>

Prescriber Segment Segment Identification (111-AM) = "Ø3"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
411-DB	PRESCRIBER ID	National Provider ID	RW	<i>Imp Guide:</i> Required if this field could result in different coverage or patient financial responsibility.  Required if necessary for state/federal/regulatory agency programs.  <i>Payer Requirement: NPI of prescriber is required.</i>
427-DR	PRESCRIBER LAST NAME		RW	<i>Imp Guide:</i> Required when the Prescriber ID (411-DB) is not known.  Required if needed for Prescriber ID (411-DB) validation/clarification.  <i>Payer Requirement: Same as Imp Guide</i>
498-PM	PRESCRIBER PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed for Workers' Compensation.  Required if needed to assist in identifying the prescriber.  Required if needed for Prior Authorization process.  <i>Payer Requirement: Same as Imp Guide.</i>

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 1 - Other Payer Amount Paid Repetitions Only		
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only	X	
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill	
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	Ø1 – Ø9	M	Submit value appropriate to the order in which the payer was billed.
339-6C	OTHER PAYER ID QUALIFIER	Ø1=National Payer ID Ø3=Bank Information Number (BIN)	RW	<i>Imp Guide:</i> Required if Other Payer ID (34Ø-7C) is used.  <i>Payer Requirement: Submit qualifier appropriate to the value submitted in Other Payer ID (34Ø-7C).</i>
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: Submit National Payer ID (also referenced as "HPID") of the primary payer when available, otherwise the BIN used for claim submission to the other payer is required.</i>

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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.
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> Iowa Medicaid only accepts the 06=Patient Pay Amount.  Components of Patient Pay (01-05, 07-13) 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.  <i>Payer Requirement:</i> 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, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required if DUR information needs to be sent

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement: Same as Imp. Guide</i>
44Ø-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: Same as Imp. Guide</i>
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.  <i>Payer Requirement: Same as Imp. Guide</i>
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: Same as Imp. Guide</i>
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: Same as Imp. Guide</i>
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: Same as Imp. Guide</i>

Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
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 Iowa Medicaid.

Compound Segment Segment Identification (111-AM) = "1Ø"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

	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.  <i>Payer Requirement:</i> Required when the pharmacy is seeking compensation for the individual ingredient.
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).

\*\* 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: Iowa Medicaid Enterprise	Date: December 16, 2011
Plan Name/Group Name: Iowa Medicaid	BIN: 011933 PCN: IAPOP

**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	

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) <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	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 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		
This Segment is situational	X	<i>Returned when needed for transmission-level messaging.</i>

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) <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/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
This Segment is situational		

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) <i>Payer Situation</i>
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

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

Field #	Response Status Segment Identification (111-AM) = "21"	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
503-F3	AUTHORIZATION NUMBER		RW	<i>Imp Guide:</i> Required if needed to identify the transaction.  <i>Payer Requirement:</i> Will be returned
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	Free Text 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		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 Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent	X	

Field #	Response Claim Segment Identification (111-AM) = "22"	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

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

Response Pricing Segment Identification (111-AM) = "23"	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
505-F5	PATIENT PAY AMOUNT		R	Reflects the Medicaid Copay amount
506-F6	INGREDIENT COST PAID		R	
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: Same as Imp Guide</i>
558-AW	FLAT SALES TAX AMOUNT PAID		RW	<i>Imp Guide:</i> Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (Ø) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement.  <i>Payer Requirement: Same as Imp Guide, but will never be greater than Ø.</i>
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.  Required if Percentage Sales Tax Amount Submitted (482-GE) is greater than zero (Ø).  Required if Percentage Sales Tax Rate Paid (560-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used.  <i>Payer Requirement: Same as Imp Guide, but will never be greater than Ø.</i>
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: Same as Imp Guide</i>
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: Same as Imp Guide</i>
564-J3	OTHER AMOUNT PAID QUALIFIER		RW	<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used.  <i>Payer Requirement: Same as Imp Guide</i>
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 (480-H9) is greater than zero (Ø).  <i>Payer Requirement: Same as Imp Guide, but will never be greater than Ø.</i>
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: Same as Imp Guide</i>
509-F9	TOTAL AMOUNT 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>
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: Return 14 = Other Payer-Patient Responsibility Amount to Indicate reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ)</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: Same as Imp Guide</i>
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes deductible  <i>Payer Requirement: Same as Imp Guide</i>
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: Same as Imp Guide</i>
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: Same as Imp Guide</i>
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: Same as Imp Guide</i>
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: Same as Imp Guide</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 (505-F5). The resulting Patient Pay Amount (505-F5) must be greater than or equal to zero.  <i>Payer Requirement: Same as Imp Guide</i>
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another  <i>Payer Requirement: Same as Imp Guide</i>
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a Brand drug.  <i>Payer Requirement: Same as Imp Guide</i>

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
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-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 (505-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

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

Response DUR/PPS Segment Segment Identification (111-AM) = "24"				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.	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		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.

Response DUR/PPS Segment Segment Identification (111-AM) = "24"				Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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, Payer Situation
This Segment is always sent	X	

Response Transaction Header Segment				Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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, 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 Billing/Claim Rebill 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 Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Response Insurance Segment Segment Identification (111-AM) = "25"				Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

	<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>
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 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	
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
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03=Processor/PBM Telephone Number	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		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 Billing/Claim Rebill 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 Billing/Claim Rebill Accepted/Rejected</b>
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Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

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

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

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill Rejected/Rejected Payer Situation
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	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, Payer Situation
This Segment is always sent		
This Segment is situational	X	Returned when needed for transmission-level messaging

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill Rejected/Rejected 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 Billing/Claim Rebill Rejected/Rejected If Situational, Payer Situation
This Segment is always sent	X	

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill Rejected/Rejected Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
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

	<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>
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		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used.  <i>Payer Requirement:</i> Same as Imp Guide
55Ø-8F	HELP DESK PHONE NUMBER		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

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

# IOWA MEDICAID NCPDP VERSION D CLAIM REVERSAL

## REQUEST CLAIM REVERSAL PAYER SHEET

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

### GENERAL INFORMATION

Payer Name: Iowa Medicaid Enterprise	Date: December 16, 2011	
Plan Name/Group Name: Iowa Medicaid	BIN: 011933	PCN: IAPOP

### 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
NOT USED	<b>NA</b>	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?)	Iowa Medicaid will accept reversal/ resubmission within a 2 year time period from 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.0*.

Transaction Header Segment Questions	Check	Claim Reversal <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used	X	

Field #	Transaction Header Segment <i>NCPDP Field Name</i>	Value	Payer Usage	Claim Reversal <i>Payer Situation</i>
101-A1	BIN NUMBER	011933	M	BIN for Iowa Medicaid
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B2	M	Claim Reversal
104-A4	PROCESSOR CONTROL NUMBER	IAPOP	M	
109-A9	TRANSACTION COUNT	01 - 04	M	01=One Occurrence 02=Two Occurrences 03=Three Occurrences 04= Four Occurrences
202-B2	SERVICE PROVIDER ID QUALIFIER	01=National Provider Identifier (NPI)	M	Only the National Provider ID (NPI) is supported
201-B1	SERVICE PROVIDER ID	.	M	NPI of the submitting pharmacy
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	No other values required

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

	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	Ø1 = 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).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	ØØ – For compound submissions Ø1 – Universal Product Code (UPC) Ø2 – Health Related Item (HRI) Ø3 – National Drug Code (NDC)	M	Use ØØ only when submitting claims for compounded prescription claims, in all other instances use the qualifier appropriate for the product ID in field 4Ø7-D7
4Ø7-D7	PRODUCT/SERVICE ID		M	Use 'Ø' only when submitting claims for compounded prescriptions, in all other instances use the ID of the product being dispensed
4Ø3-D3	FILL NUMBER	Same value as original Claim Billing, if sent	RW	<i>Imp Guide:</i> Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (4Ø2-D2) occur on the same day.  <i>Payer Requirement: Same as Imp Guide</i>
3Ø8-C8	OTHER COVERAGE CODE	Same value as original Claim Billing, if sent	RW	<i>Imp Guide:</i> Required if needed by receiver to match the claim that is being reversed.  <i>Payer Requirement: Same as Imp Guide</i>

\*\* 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: Iowa Medicaid Enterprises	Date: December 16, 2011
Plan Name/Group Name: Iowa Medicaid	BIN: 011933 PCN: IAPOP

**CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE**

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

Field #	Response Transaction Header Segment NCPDP Field Name	Value	Payer Usage	Claim Reversal – Accepted/Approved 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/Approved If Situational, Payer Situation
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 Reversal – Accepted/Approved Payer Situation
504-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	

Field #	Response Status Segment Segment Identification (111-AM) = "21"	Value	Payer Usage	Claim Reversal – Accepted/Approved Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	
503-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
130-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

Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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> Same as Imp Guide
55Ø-8F	HELP DESK PHONE NUMBER		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

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 = Rx Billing	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).
4Ø2-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
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/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 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 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
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	Ø3=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		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

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 Situation

	<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 = Rx Billing	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

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

	<b>Response Transaction Header Segment</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>
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	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	

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

	<b>Response Message Segment Segment Identification (111-AM) = "20"</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>
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.

<b>Response Status Segment Questions</b>	<b>Check</b>	<b>Claim Reversal - Rejected/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 Reversal – Rejected/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		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

Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Rejected/Rejected	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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> Same as Imp Guide
55Ø-8F	HELP DESK PHONE NUMBER		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

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