**Change Healthcare**

**NCPDP Version D.0 Payer Sheet**

**\*\*\*Commercial\*\*\***

***Claim Billing/Claim Rebill (B1/B3)***

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

**GENERAL INFORMATION**

|  |  |
| --- | --- |
| Payer Name: Change HealthCare | Date: 01/01/2019 |
| Plan Name/Group Name: Triplefin, LLC | BIN: 018844 | PCN: 3F |
| Processor: Change Healthcare |  |  |
| Effective as of: 04/04/2018 |
| NCPDP Data Dictionary Version Date: October 2016 | NCPDP External Code List Version Date: October 2016 |
| Contact/Information Source: Pharmacy Helpdesk 800-433-4893 E-mail: SelectRx\_Help\_Desk@changehealthcare.com |  |
| Certification Testing Window: Certification Not Required  |
| Provider Relations Help Desk Info: Provider.relations@changehealthcare.com  |
| Other versions supported: Only D.Ø |
|  |

**OTHER TRANSACTIONS SUPPORTED**

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

|  |  |
| --- | --- |
| **Transaction Code** | **Transaction Name** |
|  |  |
|  |  |

**Field Legend for Columns**

| **Payer Usage** **Column** | **Value** | **Explanation** | **Payer Situation Column** |
| --- | --- | --- | --- |
| MANDATORY | **M** | The Field is mandatory for the Segment in the designated Transaction. | No |
| Required | **R** | The Field has been designated with the situation of "Required" for the Segment in the designated Transaction. | No |
| Qualified Requirement | **RW** | “Required when”. The situations designated have qualifications for usage ("Required if x", "Not required if y"). | Yes |

**Fields that are not used in the Claim Billing/Claim 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 |  |  |

|  | **Transaction Header Segment**  |  |  | **Claim Billing/Claim Rebill** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 1Ø1-A1 | BIN Number | See general information above | M |  |
| 1Ø2-A2 | Version/Release Number | DØ | M |  |
| 1Ø3-A3 | Transaction Code | B1, B3 | M |  |
| 1Ø4-A4 | Processor Control Number | See above | M | Varies by plan |
| 1Ø9-A9 | Transaction Count | 1-4 | M |  |
| 2Ø2-B2 | Service Provider ID Qualifier | 01 - NPI | M |  |
| 2Ø1-B1 | Service Provider ID  | NPI | M |  |
| 4Ø1-D1 | Date of Service |  | M |  |
| 11Ø-AK | Software Vendor/Certification ID | blank | M |  |

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

|  | **Insurance Segment****Segment Identification (111-AM) = “Ø4”** |  |  | **Claim Billing/Claim Rebill** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 3Ø2-C2 | CARDHOLDER ID |  | M |  |
| 3Ø1-C1 | GROUP ID |  | R | *Imp Guide:* Required if necessary for state/federal/regulatory agency programs.Required if needed for pharmacy claim processing and payment. |
| 3Ø3-C3 | PERSON CODE |  | R | *Imp Guide:* Required if needed to uniquely identify the family members within the Cardholder ID.*Payer Requirement: Same as Implementation guide* |
| 3Ø6-C6 | PATIENT RELATIONSHIP CODE |  | R | *Imp Guide:* Required if needed to uniquely identify the relationship of the Patient to the Cardholder.*Payer Requirement: Same as Implementation guide* |
|  |  |  |  |  |

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| --- | --- | --- |
| **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) = “Ø1”** |  |  | **Claim Billing/Claim Rebill** |
| --- | --- | --- | --- | --- |
| *Field*  | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 3Ø4-C4 | DATE OF BIRTH |  | R |  |
| 3Ø5-C5 | PATIENT GENDER CODE |  | R |  |
| 31Ø-CA | PATIENT FIRST NAME |  | R | *Imp Guide:* Required when the patient has a first name. |
| 311-CB | PATIENT LAST NAME |  | R |  |

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| --- | --- | --- |
| **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 |  |  |

|  | **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 | *Imp Guide:* For Transaction Code of “B1”, 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 | 03 - NDC | M | 00 if Compound Code (406-D6) = 2 |
| 4Ø7-D7 | Product/Service ID | 11-digit NDC  | M | 0 if Compound Code (406-D6) = 2 |
| 442-E7 | QUANTITY DISPENSED | Format 9(7)V999 | R |  |
| 4Ø3-D3 | FILL NUMBER | New = 00 must be sent | R |  |
| 4Ø5-D5 | DAYS SUPPLY |  | R |  |
| 4Ø6-D6 | COMPOUND CODE | 1 = Not a compound2 = Compound | R | Refer to Compound Segment when Compound Code (406-D6) = 2 |
| 4Ø8-D8 | DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE |  | R |  |
| 414-DE | DATE PRESCRIPTION WRITTEN |  | R |  |
| 415-DF | NUMBER OF REFILLS AUTHORIZED |  | R | *Imp Guide:* Required if necessary for plan benefit administration.*Payer Requirement: Same as Implementation guide* |
| 419-DJ | PRESCRIPTION ORIGIN CODE |  | R | *Imp Guide:* Required if necessary for plan benefit administration.*Payer Requirement: Same as Implementation guide* |
| 354-NX | SUBMISSION CLARIFICATION CODE COUNT | Maximum count of 3. | RW | *Imp Guide:* Required if Submission Clarification Code (42Ø-DK) is used.*Payer Requirement: Same as implementation guide* |
| 42Ø-DK | SUBMISSION CLARIFICATION CODE |  | RW | *Imp Guide:* 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.*Payer Requirement: Same as Implementation guide* |
| 46Ø-ET | QUANTITY PRESCRIBED |  | RW | *Imp Guide:* Required for all drugs dispensed as Schedule II. *Payer Requirement: Must submit quantity Prescribed and Quantity dispensed Number of Refills Authorized should be 0* |
| 3Ø8-C8 | OTHER COVERAGE CODE | 0 = Not Specified by Patient1 = No Other Coverage2 = Other Coverage Exists – Payment Collected3 = Other Coverage Exist – Claim Not Covered4 = Other Coverage Exist – Payment Collected | RW | *Imp Guide:* Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers.Required for Coordination of Benefits.*Payer Requirement: Same as Implementation guide**\*Requires COB Segment to be sent* |
| 461-EU | PRIOR AUTHORIZATION TYPE CODE | 1 = Prior Authorization | RW | *Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility.*Payer Requirement: Same as Implementation guide* |
| 462-EV | PRIOR AUTHORIZATION NUMBER SUBMITTED | If Applicable to Rx | RW | *Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility.*Payer Requirement: Same as Implementation guide* |
| 995-E2 | ROUTE OF ADMINISTRATION |  | RW | *Imp Guide:* Required if specified in trading partner agreement.*Payer Requirement: When compound Code (406 – D6) = 2* |

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| --- | --- | --- |
| **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* |
| 4Ø9-D9 | INGREDIENT COST SUBMITTED |  | R |  |
| 412-DC | DISPENSING FEE SUBMITTED |  | R | *Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.  |
| 433-DX | PATIENT PAID AMOUNT SUBMITTED |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. |
| 478-H7 | OTHER AMOUNT CLAIMED SUBMITTED COUNT | Maximum count of 3.  | RW | *Imp Guide:* Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.*Payer Requirement: Same as Implementation guide* |
| 479-H8  | OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER |  | RW | *Imp Guide:* Required if Other Amount Claimed Submitted (48Ø-H9) is used.*Payer Requirement: Same as Implementation guide* |
| 48Ø-H9 | OTHER AMOUNT CLAIMED SUBMITTED |  | RW | *Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement: Same as Implementation guide* |
| 481-HA | FLAT SALES TAX AMOUNT SUBMITTED |  | RW | *Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement: Same as Implementation guide* |
| 482-GE | PERCENTAGE SALES TAX AMOUNT SUBMITTED |  | RW | *Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement: Same as Implementation guide* |
| 483-HE | PERCENTAGE SALES TAX RATE SUBMITTED  |  | RW | *Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used.Required if this field could result in different pricing.Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).*Payer Requirement: Same as Implementation guide* |
| 484-JE  | PERCENTAGE SALES TAX BASIS SUBMITTED |  | RW | *Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used. Required if this field could result in different pricing.Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).*Payer Requirement: Same as Implementation guide* |
| 426-DQ | USUAL AND CUSTOMARY CHARGE |  | R | *Imp Guide:* Required if needed per trading partner agreement. |
| 43Ø-DU | GROSS AMOUNT DUE |  | R |  |
| 423-DN | BASIS OF COST DETERMINATION |  | R | *Imp Guide:* Required if needed for receiver claim/encounter adjudication. |

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| **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) = “Ø3”** |  |  | **Claim Billing/Claim Rebill** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 466-EZ  | PRESCRIBER ID QUALIFIER  | 01 = NPI12 = DEA | R | *Imp Guide:* Required if Prescriber ID (411-DB) is used. |
| 411-DB | PRESCRIBER ID |  | R | *Imp Guide:* Required if this field could result in different coverage or patient financial responsibility.Required if necessary for state/federal/regulatory agency programs. |
| 427-DR | PRESCRIBER LAST NAME |  | RW | *Imp Guide:* Required when the Prescriber ID (411-DB) is not known.Required if needed for Prescriber ID (411-DB) validation/clarification.*Payer Requirement: Required when submitting DEA* |
| 364-2J | PRESCRIBER FIRST NAME |  | RW | *Imp Guide:* Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.*Payer Requirement:* Required When submitting DEA |
| 365-2K | PRESCRIBER STREET ADDRESS |  | RW | *Imp Guide:* Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.*Payer Requirement: Required when submitting DEA* |
| 366-2M | PRESCRIBER CITY ADDRESS |  | RW | *Imp Guide:* Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.*Payer Requirement: Required when submitting DEA* |
| 367-2N | PRESCRIBER STATE/PROVINCE ADDRESS |  | RW | *Imp Guide:* Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.*Payer Requirement: Required when submitting DEA* |
| 368-2P | PRESCRIBER ZIP/POSTAL ZONE |  | RW | *Imp Guide:* Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs.*Payer Requirement: Required When submitting DEA* |

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| **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 | X | Required only for secondary, Tertiary, etc. claims Other Coverage Code (308-C8) = 0, 1, 3  |

|  | **Coordination of Benefits/Other Payments Segment****Segment Identification (111-AM) = “Ø5”** |  |  | **Claim Billing/Claim Rebill** Scenario 1 - Other Payer Amount Paid Repetitions Only |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 337-4C | Coordination of Benefits/Other Payments Count | Maximum count of 9. | M |  |
| 338-5C | Other Payer Coverage Type |  | M |  |
| 339-6C | OTHER PAYER ID QUALIFIER | 03 = BIN | R | *Imp Guide:* Required if Other Payer ID (34Ø-7C) is used. |
| 34Ø-7C | OTHER PAYER ID  | Bin Number  | R | *Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication.*Payer Requirement: Other Payer BIN* |
| 443-E8 | OTHER PAYER DATE |  | RW | *Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. |
| 341-HB | OTHER PAYER AMOUNT PAID COUNT | Maximum count of 9. | RW | *Imp Guide:* Required if Other Payer Amount Paid Qualifier (342-HC) is used. |
| 342-HC | OTHER PAYER AMOUNT PAID QUALIFIER |  | RW | *Imp Guide:* Required if Other Payer Amount Paid (431-DV) is used. |
| 431-DV | OTHER PAYER AMOUNT PAID  |  | M | *Imp Guide:* Required if other payer has approved payment for some/all of the billing.  |
| 471-5E | OTHER PAYER REJECT COUNT | Maximum count of 5. | RW | *Imp Guide:* Required if Other Payer Reject Code (472-6E) is used. |
| 472-6E | OTHER PAYER REJECT CODE |  | RW | *Imp Guide:* Required when the other payer has denied the payment for the billing. *Payer Requirement: Required when the Other Payer has denied for the billing designated with Other Coverage Code (308 – C8) = 3* |

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| **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.. OPPRA |
|  |  |  |
| Scenario 1 - Other Payer Amount Paid Repetitions Only | X | Required only for secondary, Tertiary, etc. claims Other Coverage Code (308-C8) = 3, 8 |

|  | **Coordination of Benefits/Other Payments Segment****Segment Identification (111-AM) = “Ø5”** |  |  | **Claim Billing/Claim Rebill** Scenario 2- Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 337-4C | Coordination of Benefits/Other Payments Count | Maximum count of 9. | M |  |
| 338-5C | Other Payer Coverage Type |  | M |  |
| 339-6C | OTHER PAYER ID QUALIFIER | 03 - BIN |  | *Imp Guide:* Required if Other Payer ID (34Ø-7C) is used. |
| 34Ø-7C | OTHER PAYER ID  | BIN |  | *Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication. |
| 443-E8 | OTHER PAYER DATE |  |  | *Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. |
| 471-5E | OTHER PAYER REJECT COUNT | Maximum count of 5. |  | *Imp Guide:* Required if Other Payer Reject Code (472-6E) is used. |
| 472-6E | OTHER PAYER REJECT CODE |  |  | *Imp Guide:* Required when the other payer has denied the payment for the billing.  |
| 353-NR | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT | Maximum count of 25. |  | *Imp Guide:* Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. |
| 351-NP | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER |  |  | *Imp Guide:* Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. |
| 352-NQ | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT |  |  | *Imp Guide:* Required if necessary for patient financial responsibility only billing.Required if necessary for state/federal/regulatory agency programs.Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted.. |

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| --- | --- | --- |
| **DUR/PPS Segment Questions** | **Check** | **Claim Billing/Claim Rebill** If Situational, *Payer Situation* |
| This Segment is always sent |  |   |
| This Segment is situational | X | For use to define professional services or override clinical edits |

|  | **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. | R | *Imp Guide:* Required if DUR/PPS Segment is used. |
| 439-E4 | REASON FOR SERVICE CODE |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.Required if this field affects payment for or documentation of professional pharmacy service. |
| 44Ø-E5 | PROFESSIONAL SERVICE CODE |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.Required if this field affects payment for or documentation of professional pharmacy service. |
| 441-E6 | RESULT OF SERVICE CODE |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.Required if this field affects payment for or documentation of professional pharmacy service. |
| 474-8E | DUR/PPS LEVEL OF EFFORT |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.Required if this field affects payment for or documentation of professional pharmacy service. |
| 475-J9 | DUR CO-AGENT ID QUALIFIER |  | R | *Imp Guide:* Required if DUR Co-Agent ID (476-H6) is used. |
| 476-H6 | DUR CO-AGENT ID |  | R | *Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.Required if this field affects payment for or documentation of professional pharmacy service. |

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| --- | --- | --- |
| **Compound Segment Questions** | **Check** | **Claim Billing/Claim Rebill** If Situational, *Payer Situation* |
| This Segment is always sent |  |   |
| This Segment is situational | X | Required when Compound Code (406-D6) = 2 |

|  | **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 | 03 - NDC | M |  |
| 489-TE | Compound Product ID  | 11 digit NDC | M |  |
| 448-ED | Compound Ingredient Quantity |  | M |  |
| 449-EE | COMPOUND INGREDIENT DRUG COST |  |  | *Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. |
| 49Ø-UE | COMPOUND INGREDIENT BASIS OF COST DETERMINATION |  |  | *Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. |

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

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

***Claim Reversal (B2) NCPDP Version D.0***

**GENERAL INFORMATION**

|  |  |
| --- | --- |
| Payer Name: Change Healthcare | Date: 04/04/2018 |
| Plan Name/Group Name: Change Healthcare Commercial | BIN:004682 | PCN: CN or Varies by Plan refer to Coupon or Card |
| Plan Name/Group Name: Change Healthcare Commercial | BIN:600426 | PCN: 54 or Varies by Plan refer to Coupon or Card |
| Plan Name/Group Name: Easy Save Programs | BIN:016184 | PCN: PW |
| Plan Name/Group Name: Connective Rx Custom Network | BIN:019579 | PCN: PW |
|  |  |  |

**Field Legend for Columns**

| **Payer Usage** **Column** | **Value** | **Explanation** | **Payer Situation Column** |
| --- | --- | --- | --- |
| MANDATORY | **M** | The Field is mandatory for the Segment in the designated Transaction. | No |
| Required | **R** | The Field has been designated with the situation of “Required” for the Segment in the designated Transaction. | No |
| Qualified Requirement | **RW** | “Required when”. The situations designated have qualifications for usage (“Required if x”, “Not required if y”). | Yes |
| NOT USED | **NA** | The Field is not used for the Segment in the designated Transaction. | No |

|  |  |
| --- | --- |
| **Question** | **Answer** |
| What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?) | Varies by plan |

**Claim Reversal Transaction**

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

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

|  | **Transaction Header Segment** |  |  | **Claim Reversal** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 1Ø1-A1 | BIN Number | See above | M |  |
| 1Ø2-A2 | Version/Release Number | DØ | M |  |
| 1Ø3-A3 | Transaction Code | B2 | M |  |
| 1Ø4-A4 | Processor Control Number | Varies by Plan | M |  |
| 1Ø9-A9 | Transaction Count | 1-4 | M |  |
| 2Ø2-B2 | Service Provider ID Qualifier | 01 = NPI | M |  |
| 2Ø1-B1 | Service Provider ID  |  | M |  |
| 4Ø1-D1 | Date of Service |  | M |  |
| 11Ø-AK | Software Vendor/Certification ID | All Spaces | M |  |

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

|  | **Claim Segment****Segment Identification (111-AM) = “Ø7”** |  |  | **Claim Reversal** |
| --- | --- | --- | --- | --- |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 455-EM | PREscription/Service Reference Number Qualifier | 1 = Rx Billing | M | *Imp Guide:* For Transaction Code of “B2”, in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing). |
| 4Ø2-D2 | Prescription/Service Reference Number |  | M |  |
| 436-E1 | Product/Service ID Qualifier | 03=NDC | M |  |
| 4Ø7-D7 | Product/Service ID | 11-digit NDC | M |  |
| 4Ø3-D3 | FILL NUMBER | New = 00  | M | *Imp Guide:* Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (4Ø2-D2) occur on the same day. |
| 3Ø8-C8 | OTHER COVERAGE CODE |  | M | *Imp Guide:* Required if needed by receiver to match the claim that is being reversed.*Payer Requirement:* Must match original claim being reversed.  |
| 147-U7 | pharmacy service type |  |  | *Imp Guide:* Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer. |
| 337-4C | Coordination of Benefits/Other Payments Count | Maximum count of 9. | M |  |
| 338-5C | Other Payer Coverage Type |  | M |  |
|  |  |  |  |  |
| **\*\* End of Request Claim Reversal (B2) Payer Sheet Template\*\*** |