ForwardHealth Payer Sheet: National Council for Prescription Drug Programs (NCPDP) Version D.Ø

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INTRODUCTION

General Information

Payer Name: ForwardHealth	Payer Sheet Publication Date: October 2025
Processor: Gainwell Technologies LLC	
Effective as of: October 15, 2Ø25	NCPDP Telecommunication Standard Version / Release #: D.Ø
NCPDP Data Dictionary Version Date: July 2ØØ7	NCPDP External Code List Version Date: October 2Ø24 NCPDP Emergency Telecommunication External Code List Value Addendum: January 2023
Contact / Information Source: ForwardHealth Electronic Data Interchange (EDI) Department at 866-416-4979 ForwardHealth Portal at www.forwardhealth.wi.gov/	
Provider Relations Help Desk Info: 8ØØ-947-9627 between the hours of 8:3Ø a.m.–4:3Ø p.m. Monday through Friday	
Other versions supported: None	

Transactions Supported

Transaction Code	Transaction Name
B1	Claim Billing Request and Claim Billing Responses (Accepted/Paid [or Duplicate of Paid]; Accepted/Rejected; Rejected/Rejected)
B2	Claim Reversal Request and Claim Reversal Responses (Accepted/Approved; Accepted/Rejected; Rejected/Rejected)
P2	Prior Authorization Reversal and Prior Authorization Reversal Responses (Accepted/Approved; Accepted/Rejected; Rejected/Rejected)
P3	Prior Authorization Inquiry and Prior Authorization Inquiry Responses (Accepted/Approved; Accepted/Rejected; Rejected/Rejected)
P4	Prior Authorization Request Only and Prior Authorization Request Only Responses (Accepted/Captured; Accepted/Rejected; Rejected/Rejected)

Payer Sheet Audience

Payer sheets are intended for information technology and/or systems staff who will be coding billing systems or software for compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Purpose of Payer Sheets

The information contained in this payer sheet applies to ForwardHealth, which includes the following programs: BadgerCare Plus, Wisconsin Medicaid, SeniorCare, Wisconsin Chronic Disease Program, and HIV Drug Assistance Program.

This payer sheet is designed to be used with the National Council for Prescription Drug Programs (NCPDP) Telecommunication Guide Version D.Ø adopted by HIPAA and provides information specific to ForwardHealth programs. The payer sheet details the way to create HIPAA-compliant NCPDP transactions for ForwardHealth and explains how ForwardHealth

creates HIPAA-compliant NCPDP response transactions. The payer sheet provides trading partners with a guide to successfully exchange electronic transactions with ForwardHealth.

ForwardHealth will accept and process NCPDP transactions described in this payer sheet that are compliant with the HIPAA standards. Additionally, compliant transactions are processed in accordance with ForwardHealth policy and must contain information required by ForwardHealth as outlined in this payer sheet.

Refer to the payer sheet for questions about ForwardHealth-specific requirements for submitting NCPDP transactions. For questions regarding appropriate billing procedures, refer to the appropriate policy area of the ForwardHealth Online Handbook. For further information not defined in this payer sheet, contact the EDI Department at 866-416-4979.

Information About Transmission Syntax and Structure

Refer to the NCPDP Telecommunication Standard Implementation Guide Version D.Ø for the structure and syntax of the transaction(s) within the transmission.

In this document, the Segment Identification (112-AM) fields are not shown. Segment, group, and field separators are not shown as they are part of the syntax. These fields are not shown because they are part of the underlying structure of the transaction and are covered in the guide. The payer sheet shows the business and plan requirements.

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

The only fields that are listed in the payer sheet are those used in the transaction according to the NCPDP standard and those with situational rules that are used by ForwardHealth. If a field is not listed in the payer sheet, it is not required for the transaction and is not used by ForwardHealth.

Copyright Information

B1 CLAIM BILLING REQUEST

Transaction Header Segment Questions	**Check**	**Claim Billing** 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	

	Transaction Header Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	61Ø499 Ø16929	M	***Payer Requirement:*** Use BIN Number 61Ø499 for all claims except HDAP claims. Use BIN Number Ø16929 for HDAP claims.
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	Enter "WIPARTD" for SeniorCare, Wisconsin Chronic Disease Program (WCDP), and HIV Drug Assistance Program (HDAP) members that are also enrolled in a Medicare Part D Prescription Plan (PDP) to ensure coordination with the TrOOP facilitator.	M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	• Ø1 = National Provider Identifier (NPI) • Ø5 = Medicaid *Note:* "Ø5" is valid for "atypical" providers only.	M	
2Ø1-B1	SERVICE PROVIDER ID	*Note:* "Atypical" providers (i.e., specialized medical vehicle providers, blood banks, and Community Care Organizations) should enter the eight-digit or nine-digit identification number assigned by ForwardHealth.	M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		M	

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

	Insurance Segment Segment Identification (111-AM) = "Ø4"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID	Enter the 1Ø-digit ForwardHealth member identification number.	M	
3Ø1-C1	GROUP ID	TXIX WCDP HDAP	RW	***Imp Guide:*** Required if necessary for state/federal/regulatory agency programs. Required if needed for pharmacy claim processing and payment. ***Payer Requirement:*** Required. Enter value "TXIX" to indicate Wisconsin Medicaid, BadgerCare Plus, and SeniorCare or "WCDP" to indicate the Wisconsin Chronic Disease Program or "HDAP" to indicate HIV Drug Assistance Program.

Patient Segment Questions	**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Patient Segment Segment Identification (111-AM) = "Ø1"			**Claim Billing**
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		RW	***Imp Guide:*** Required when the patient has a first name. ***Payer Requirement:*** Required.
311-CB	PATIENT LAST NAME		R	
3Ø7-C7	PLACE OF SERVICE	• Ø1 = Pharmacy • 13 = Assisted Living Facility • 14 = Group Home • 32 = Nursing Facility • 34 = Hospice • 5Ø = Federally Qualified Health Center • 65 = End-Stage Renal Disease Treatment Facility • 72 = Rural Health Clinic	RW	***Imp Guide:*** Required if this field could result in different coverage, pricing, or patient financial responsibility. ***Payer Requirement:*** Required.

Claim Segment Questions	**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent.	X	
ForwardHealth does not support partial fills.	X	

	Claim Segment Segment Identification (111-AM) = "Ø7"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	• ØØ = Not Specified • Ø3 = National Drug Code (NDC)	M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	*Note:* Multi-ingredient compounds are not valid for WCDP or HDAP.	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	• Ø = No Product Selection Indicated • 1 = Substitution Not Allowed by Prescriber	R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
419-DJ	PRESCRIPTION ORIGIN CODE		RW	***Imp Guide:*** Required if necessary for plan benefit administration. ***Payer Requirement:*** Required.
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 Imp Guide.
42Ø-DK	SUBMISSION CLARIFICATION CODE	• 2 = Other Override • 8 = Process Compound for Approved Ingredients • 2Ø = 34ØB—Indicates that, prior to providing service, the pharmacy has determined the product being billed is purchased pursuant to rights available under Section 34ØB of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 34ØB(a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB[a][8]).	RW	***Imp Guide:*** Required if clarification is needed and value submitted is greater than zero (Ø). Occurs the number of times identified in Submission Clarification Code Count (354-NX). 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:*** Enter "2" to indicate claim should be processed as a 340B Drug Pricing Program (340B Program) claim even though a discrepancy exists with the provider being on the Health Resources & Services Administration (HRSA) Exclusion file.

	Claim Segment Segment Identification (111-AM) = "Ø7"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		• 99 = Other		Enter "8" to indicate a multi-ingredient compound drug claim to specify acceptance of payment for only those ingredients covered. Enter "20" to indicate 340B stock was used to fill the prescription. Enter "99" to indicate the 340B provider was not able to purchase the drug being billed at a 340B rate. *Note:* Not used by WCDP or HDAP.
46Ø-ET	Quantity Prescribed		RW	***Imp Guide:*** Required when the transmission is for a Schedule II drug as defined in 21 C.F.R. § 1308.12. ***Payer Requirement:*** Same as Imp Guide.
3Ø8-C8	OTHER COVERAGE CODE	• Ø = Not Specified by patient • 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	***Imp Guide:*** Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers. Required for Coordination of Benefits. ***Payer Requirement:*** Same as Imp Guide.
429-DT	SPECIAL PACKAGING INDICATOR	• Ø = Not Specified • 1 = Not Unit Dose • 2 = Manufacturer Unit Dose • 3 = Pharmacy Unit Dose • 4 = Custom Packaging • 5 = Multi Drug Compliance Packaging	RW	***Imp Guide:*** Required if this field could result in different coverage, pricing, or patient financial responsibility. ***Payer Requirement:*** Enter 4 or 5 to indicate repackaging.
461-EU	PRIOR AUTHORIZATION TYPE CODE	4 = Exemption from Copay and/or Co-Insurance	RW	***Imp Guide:*** Required if this field could result in different coverage, pricing, or patient financial responsibility. ***Payer Requirement:*** Required to indicate a copayment exemption for Medicaid. *Note:* Copayment exemption is not valid for SeniorCare, WCDP, or HDAP members.

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

	Pricing Segment Segment Identification (111-AM) = "11"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		RW	***Imp Guide:*** Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. Zero (Ø) is a valid value. ***Payer Requirement:*** Same as Imp Guide.
426-DQ	USUAL AND CUSTOMARY CHARGE		RW	***Imp Guide:*** Required if needed per trading partner agreement. ***Payer Requirement:*** Required.
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		RW	***Imp Guide:*** Required if needed for receiver claim/encounter adjudication. ***Payer Requirement:*** Required.

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

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = National Provider Identifier (NPI)	RW	***Imp Guide:*** Required if Prescriber ID (411-DB) is used. ***Payer Requirement:*** Same as Imp Guide.
411-DB	PRESCRIBER ID		RW	***Imp Guide:*** Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/ regulatory agency programs.
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	01 = National Provider Identifier (NPI) 02 = Blue Cross 03 = Blue Shield 04 = Medicare 05 = Medicaid 06 = UPIN (Unique Physician/Practitioner Identification Number) 08 = State License 09 = TRICARE 10 = Health Industry Number (HIN) 11 = Federal Tax ID 12 = Drug Enforcement Administration (DEA)	RW	***Imp Guide****:* Required if Primary Care Provider ID (421-DL) is used. ***Payer Requirement:*** Same as Imp Guide.

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		Number 13 = State Issued 14 = Plan Specific 15 = HCID (HC IDea) 99 = Other		
421-DL	PRIMARY CARE PROVIDER ID		RW	***Imp Guide****:* Optional ***Payer Requirement:*** This field may be used to provide additional information when it comes to indicating another provider (such as a federally qualified health center) referred the member to the billing provider.

Coordination of Benefits/Other Payments Segment Questions	**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent.		
This Segment is Situational.	X	This segment is used when payment/denial information from other commercial health insurance coverage is required for claims adjudication.
Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	X	

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing**
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	99 = Other	RW	***Imp Guide:*** Required if Other Payer ID (34Ø-7C) is used. ***Payer Requirement:*** Same as Imp Guide.
34Ø-7C	OTHER PAYER ID	• PARTD = Medicare Part D • PARTB = Medicare Part B • COMM = Commercial Insurance	RW	***Imp Guide:*** Required if identification of the Other Payer is necessary for claim/ encounter adjudication. ***Payer Requirement:*** Enter "PARTD" for Medicare Part D, "PARTB" for Medicare Part B, or "COMM" for commercial insurance.
443-E8	OTHER PAYER DATE		RW	***Imp Guide:*** Required if identification of the Other Payer Date is necessary for claim/ encounter adjudication. ***Payer Requirement:*** Required if Other Payer ID (34Ø-7C) is used.
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.

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: Same as Imp Guide.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER		RW	***Imp Guide:*** Required if Other Payer Amount Paid (431-DV) is used. ***Payer Requirement:*** Same as Imp Guide.
431-DV	OTHER PAYER AMOUNT PAID		RW	***Imp Guide:*** Required if other payer has approved payment for some/all of the billing. Zero (Ø) is a valid value. Not used for patient financial responsibility only billing. ***Payer Requirement:*** Required if Other Payer Amount Paid Qualifier (342-HC) is used.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	***Imp Guide:*** Required if Other Payer Reject Code (472-6E) is used. ***Payer Requirement:*** Same as Imp Guide.
472-6E	OTHER PAYER REJECT CODE		RW	***Imp Guide:*** Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed—claim not covered). *Note:* This field must only contain the NCPDP Reject Code (511-FB) values. ***Payer Requirement:*** Same as Imp Guide.
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	***Imp Guide:*** Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. ***Payer Requirement:*** Maximum count of 1 per other payer.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø6 = Patient Pay Amount (5Ø5-F5) as reported by previous payer. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility.	RW	***Imp Guide:*** Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. ***Payer Requirement:*** Same as Imp Guide.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	***Imp Guide:*** Required if necessary for patient financial responsibility only billing. Required if necessary for state/federal/ regulatory agency programs. Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted.

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: Required for SeniorCare when the other payer's patient pay amount is greater than zero.

DUR/PPS Segment Questions	**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent.		
This Segment is situational.	X	This segment is used to pre/override prospective Drug Utilization Review (DUR) alerts or request a multi-ingredient compound dispensing fee.

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Maximum count of 9.	RW	***Imp Guide:*** Required if DUR/PPS Segment is used. ***Payer Requirement:*** Same as Imp Guide.
439-E4	REASON FOR SERVICE CODE		RW	***Imp Guide:*** Required if this field 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. ***Payer Requirement:*** Required to pre-override prospective DUR.
44Ø-E5	PROFESSIONAL SERVICE CODE		RW	***Imp Guide:*** Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. ***Payer Requirement:*** Required to pre/override prospective DUR.
441-E6	RESULT OF SERVICE CODE		RW	***Imp Guide:*** Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. ***Payer Requirement:*** Required to pre/override prospective DUR.
474-8E	DUR/PPS LEVEL OF EFFORT		RW	***Imp Guide:*** Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. ***Payer Requirement:*** Required to request a multi-ingredient compound dispensing fee. *Note:* Not used by WCDP or HDAP.

Compound Segment Questions	**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent.		
This Segment is situational.	X	This segment is required to submit a claim for a multi-ingredient compound drug. This segment is not used for WCDP or HDAP claims.

	Compound Segment Segment Identification (111-AM) = "1Ø"			**Claim Billing**
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 count of 25.	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3 = National Drug Code (NDC)	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		RW	***Imp Guide:*** Required if needed for receiver claim determination when multiple products are billed. ***Payer Requirement:*** Required.
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION		RW	***Imp Guide:*** Required if needed for receiver claim determination when multiple products are billed. ***Payer Requirement:*** Required.

Clinical Segment Questions	**Check**	**Claim Billing** If Situational, *Payer Situation*
This Segment is always sent.		
This Segment is situational.	X	This segment is required when the drug billed requires a diagnosis. This segment is required for WCDP and HDAP.

	Clinical Segment Segment Identification (111-AM) = "13"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	***Imp Guide:*** Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. ***Payer Requirement:*** Same as Imp Guide.
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1 = *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM)	RW	***Imp Guide:*** Required if Diagnosis Code (424-DO) is used. ***Payer Requirement:*** Same as Imp Guide.

	Clinical Segment Segment Identification (111-AM) = "13"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		Ø2 = International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)		
424-DO	DIAGNOSIS CODE		RW	***Imp Guide:*** The value for this field is obtained from the prescriber or authorized representative. Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/ regulatory agency programs. ***Payer Requirement:*** Required when the drug billed requires a diagnosis. Required for WCDP and HDAP claims.

B1 CLAIM BILLING RESPONSES

Claim Billing Accepted/Paid (or Duplicate of Paid) Response

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

	Response Transaction Header Segment			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	
1Ø9-A9	TRANSACTION COUNT		M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

Response Insurance Segment Questions	**Check**	**Claim Billing Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent.		
This Segment is Situational.	X	This segment returns the ForwardHealth member identification number used for adjudication if different than the B1 request.

	Response Insurance Segment Segment Identification (111-AM) = "25"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø1-C1	GROUP ID	WISC_TXIX = Wisconsin Medicaid, BadgerCare Plus, or SeniorCare WISC_WCDP = Wisconsin Chronic Disease Program WISC_HDAP = HIV Drug Assistance Program	RW	***Imp Guide:*** Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available. Required to identify the actual group that was used when multiple group coverages exist. *Note:* This field may contain the Group ID echoed from the request. May contain the actual Group ID if unknown to the receiver. ***Payer Requirement:*** This field returns the Group ID used by ForwardHealth if field 3Ø1-C1 was submitted.
3Ø2-C2	CARDHOLDER ID		RW	***Imp Guide:*** Required if the identification to be used in future transactions is different than what was submitted on the request.

	Response Insurance Segment Segment Identification (111-AM) = "25"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: This field returns the ForwardHealth member identification number if different than the B1 request.

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

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	P = Paid D = Duplicate of Paid	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	***Imp Guide:*** Required if needed to identify the transaction. ***Payer Requirement:*** This field contains the authorization number on duplicate responses or the Internal Control Number (ICN) on paid responses.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	***Imp Guide:*** Required if Additional Message Information (526-FQ) is used. Used to qualify the number of occurrences of the Additional Message Information (526-FQ) that is included in the Response Status Segment. ***Payer Requirement:*** Same as Imp Guide.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	***Imp Guide:*** Required if Additional Message Information (526-FQ) is used. ***Payer Requirement:*** Same as Imp Guide.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	***Imp Guide:*** Required when additional text is needed for clarification or detail. ***Payer Requirement:*** This field contains Explanation of Benefit text associated with the B1 request. This field reports a member's remaining spenddown and remaining deductible amounts regardless of the member's program.

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				This field will report the duplicate ICN and payment date when a B1 request is identified as a duplicate (field 112-AN equals "D").
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	***Imp Guide:*** Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. ***Payer Requirement:*** Same as Imp Guide.

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

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

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

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø5-F5	PATIENT PAY AMOUNT		R	
5Ø6-F6	INGREDIENT COST PAID		RW	***Imp Guide:*** Required if this value is used to arrive at the final reimbursement. ***Payer Requirement:*** Same as Imp Guide.
5Ø7-F7	DISPENSING FEE PAID		RW	***Imp Guide:*** Required if this value is used to arrive at the final reimbursement.

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: Same as Imp Guide.
557-AV	PERCENTAGE TAX EXEMPT INDICATOR	4 = Payer/Plan and Patient are Tax Exempt	RW	***Imp Guide:*** Required if the sender (health plan) and/or patient is tax exempt and exemption applies to this billing. ***Payer Requirement:*** Same as Imp Guide.
558-AW	FLAT SALES TAX AMOUNT PAID		RW	***Imp Guide:*** 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. Zero (Ø) is a valid value. ***Payer Requirement:*** This field contains zero (Ø) when Flat Sales Tax Amount Submitted (481-HA) was present in the B1 request.
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		RW	***Imp Guide:*** 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). Zero (Ø) is a valid value. Required if Percentage Sales Tax Rate Paid (56Ø-AY) and Percentage Tax Basis Paid (561-AZ) are used. ***Payer Requirement:*** This field contains zero (Ø) when Percentage Sales Tax Amount Submitted (482-GE) was present in the B1 request.
521-FL	INCENTIVE AMOUNT PAID		RW	***Imp Guide:*** Required if this value is used to arrive at the final reimbursement. Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø). Zero (Ø) is a valid value. ***Payer Requirement:*** This field contains zero (Ø) when Incentive Amount Submitted (438-E3) was included in B1 request.
563-J2	OTHER AMOUNT PAID COUNT		RW	***Imp Guide:*** Maximum count of 3.

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Required if Other Amount Paid (565-J4) is used. ***Payer Requirement:*** Same as Imp Guide.
564-J3	OTHER AMOUNT PAID QUALIFIER		RW	***Imp Guide:*** Required if Other Amount Paid (565-J4) is used. ***Payer Requirement:*** Same as Imp Guide.
565-J4	OTHER AMOUNT PAID		RW	***Imp Guide:*** Required if this value is used to arrive at the final reimbursement. Required if Other Amount Claimed Submitted (48Ø-H9) is greater than zero (Ø). Zero (Ø) is a valid value. Must respond to each occurrence submitted. ***Payer Requirement:*** This field contains zero (Ø) for each occurrence when Other Amount Claimed Submitted (48Ø-H9) was present in the B1 request.
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	***Imp Guide:*** Required if this value is used to arrive at the final reimbursement. Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported. ***Payer Requirement:*** Same as Imp Guide.
5Ø9-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		RW	***Imp Guide:*** Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing. ***Payer Requirement:*** Same as Imp Guide.
513-FD	REMAINING DEDUCTIBLE AMOUNT		RW	***Imp Guide:*** Provided for informational purposes only. ***Payer Requirement:*** This field reports the member's remaining deductible regardless of the member's program.

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	***Imp Guide:*** Required if Patient Pay Amount (5Ø5-F5) includes deductible. ***Payer Requirement:*** This field reports the total amount applied to the member's spenddown and/or deductible regardless of the member's program.
518-FI	AMOUNT OF COPAY		RW	***Imp Guide:*** Required if Patient Pay Amount (5Ø5-F5) includes copay as patient financial responsibility. ***Payer Requirement:*** Same as Imp Guide.

Response DUR/PPS Segment Questions	**Check**	**Claim Billing Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent.		
This Segment is situational.	X	This segment informs providers of informational prospective DUR alerts.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum count of 9.	RW	***Imp Guide:*** Required if Reason For Service Code (439-E4) is used. ***Payer Requirement:*** Same as Imp Guide.
439-E4	REASON FOR SERVICE CODE	• AT = Additive Toxicity • DC = Drug-Disease (Inferred) • DD = Drug-Drug Interaction • ER = Overuse • HC = High Cumulative Dose • HD = High Dose • LR = Under use • MC = Drug-Disease (Reported) • NS = Insufficient Quantity • PA = Drug-Age • PG = Drug-Pregnancy • SR = Suboptimal Regimen	RW	***Imp Guide:*** Required if utilization conflict is detected. ***Payer Requirement:*** Same as Imp Guide.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		• TD = Therapeutic		
528-FS	CLINICAL SIGNIFICANCE CODE		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. ***Payer Requirement:*** Same as Imp Guide.
529-FT	OTHER PHARMACY INDICATOR		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. ***Payer Requirement:*** Same as Imp Guide.
53Ø-FU	PREVIOUS DATE OF FILL		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. ***Payer Requirement:*** Same as Imp Guide.
531-FV	QUANTITY OF PREVIOUS FILL		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. Required if Previous Date of Fill (53Ø-FU) is used. ***Payer Requirement:*** Same as Imp Guide.
532-FW	DATABASE INDICATOR		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. ***Payer Requirement:*** Same as Imp Guide.
533-FX	OTHER PRESCRIBER INDICATOR		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. ***Payer Requirement:*** Same as Imp Guide.
544-FY	DUR FREE TEXT MESSAGE	Information specific to each prospective DUR alert: • AT = (Diagnosis code from history claim indicating side effect)/ (history drug name) • DC = (Disease description of contraindication)	RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. ***Payer Requirement:*** Same as Imp Guide.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		• DD = (Brand name of drug in history causing alert) • ER = (May Refill on MM/DD/YYYY) • HC = (Claim MME is XXXXX. Caution.) • HD = (maximum recommended dose is XXX) • LR = (refill is XX days late) • MC = (Disease description of contraindication) • NS = (three month supply opportunity) • PA = (age warning/ contraindication) • PG = (pregnancy contraindication) • SR = (tablet splitting opportunity or dose consolidation opportunity) • TD = (Name of most recent history drug)		
57Ø-NS	DUR ADDITIONAL TEXT		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. ***Payer Requirement:*** This field contains the drug label names, including any claim in history, causing the prospective DUR alert.

Response Coordination of Benefits/Other Payers Segment Questions	**Check**	**Claim Billing Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent.		
This Segment is situational.	X	This segment informs providers when ForwardHealth has other insurance information for the member/date of service.

	Response Other Payers Segment Segment Identification (111-AM) = "28"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	

	Response Other Payers Segment Segment Identification (111-AM) = "28"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER	• Ø3 = Bank Information Number (BIN) • 99 = Other *Note:* Value "99" is the ForwardHealth proprietary other payer ID.	RW	***Imp Guide:*** Required if Other Payer ID (34Ø-7C) is used. ***Payer Requirement:*** Same as Imp Guide.
34Ø-7C	OTHER PAYER ID		RW	***Imp Guide:*** Required if other insurance information is available for coordination of benefits. ***Payer Requirement:*** Same as Imp Guide.
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	***Imp Guide:*** Required if other insurance information is available for coordination of benefits. ***Payer Requirement:*** Same as Imp Guide.
356-NU	OTHER PAYER CARDHOLDER ID		RW	***Imp Guide:*** Required if other insurance information is available for coordination of benefits. ***Payer Requirement:*** Same as Imp Guide.
992-MJ	OTHER PAYER GROUP ID		RW	***Imp Guide:*** Required if other insurance information is available for coordination of benefits. ***Payer Requirement:*** Same as Imp Guide.
142-UV	OTHER PAYER PERSON CODE		RW	***Imp Guide:*** Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer. ***Payer Requirement:*** Same as Imp Guide.
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	***Imp Guide:*** Required if needed to provide a support telephone number of the other payer to the receiver. ***Payer Requirement:*** Same as Imp Guide.
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	***Imp Guide:*** Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer.

	Response Other Payers Segment Segment Identification (111-AM) = "28"			**Claim Billing Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: Same as Imp Guide.
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		RW	***Imp Guide:*** Required when other coverage is known which is after the Date of Service submitted. ***Payer Requirement:*** This field will provide other insurance information on file with ForwardHealth for the member/date of service.
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		RW	***Imp Guide:*** Required when other coverage is known which is after the Date of Service submitted. ***Payer Requirement:*** This field will provide other insurance information on file with ForwardHealth for the member/date of service.

Claim Billing Accepted/Rejected Response

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

	Response Transaction Header Segment			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	
1Ø9-A9	TRANSACTION COUNT		M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

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

	Response Message Segment Segment Identification (111-AM) = "2Ø"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		RW	***Imp Guide:*** Required if text is needed for clarification or detail. ***Payer Requirement:*** This field contains the program(s) in which a member is enrolled for the date of service for the payer (Group ID [3Ø1-C1]). If the member is enrolled in multiple programs, the programs will be separated by an asterisk (*).

Response Insurance Segment Questions	**Check**	**Claim Billing 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 Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø1-C1	GROUP ID	WISC_TXIX = Wisconsin Medicaid, BadgerCare Plus, or SeniorCare	RW	***Imp Guide:*** Required if needed to identify the actual cardholder or employer group, to identify

	Response Insurance Segment Segment Identification (111-AM) = "25"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		WISC_WCDP = Wisconsin Chronic Disease Program WISC_HDAP = HIV Drug Assistance Program		appropriate group number, when available. Required to identify the actual group that was used when multiple group coverage exist. ***Payer Requirement:*** This field returns the Group ID used by ForwardHealth if field 3Ø1-C1 was submitted.
3Ø2-C2	CARDHOLDER ID		RW	***Imp Guide:*** Required if the identification to be used in future transactions is different than what was submitted on the request. ***Payer Requirement:*** Same as Imp Guide.

Response Status Segment Questions	**Check**	**Claim Billing Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	
This Segment is situational.		

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Rejected	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	***Imp Guide*:** Required if needed to identify the transaction. ***Payer Requirement:*** This field contains the authorization number.
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	***Imp Guide:*** Required if a repeating field is in error, to identify repeating field occurrence. This field must be sent when relaying error information about a repeating field or set. Note, if the Reject Code is not denoting a repeating field or set, the Reject Field Occurrence Indicator must not be sent. ***Payer Requirement:*** Same as Imp Guide.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	***Imp Guide:*** Required if Additional Message Information (526-FQ) is

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				used. Used to qualify the number of occurrences of the Additional Message Information (526-FQ) that is included in the Response Status Segment. ***Payer Requirement:*** Same as Imp Guide.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		R	***Imp Guide:*** Required if Additional Message Information (526-FQ) is used. ***Payer Requirement:*** Same as Imp Guide.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	***Imp Guide:*** Required when additional text is needed for clarification or detail. ***Payer Requirement:*** This field contains Explanation of Benefit text associated with the B1 request. This field will report the Lock-In Type and effective dates when a member is in a Lock-In program. This field will include preferred products when a non-preferred product was denied for prior authorization requirements. For SeniorCare members, additional restrictions may apply.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	***Imp Guide:*** Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. ***Payer Requirement:*** Same as Imp Guide.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3 = Processor/ PBM	RW	***Imp Guide:*** Required if Help Desk Phone Number (55Ø-8F) is used. ***Payer Requirement:*** Same as Imp Guide.
55Ø-8F	HELP DESK PHONE NUMBER		RW	***Imp Guide:*** Required if needed to provide a support telephone number to the receiver. ***Payer Requirement:*** Same as Imp Guide.

Response Claim Segment Questions	**Check**	**Claim Billing Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	
This Segment is situational.		

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	**Check**	**Claim Billing Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent.		
This Segment is situational.	X	This segment informs providers of prospective DUR alerts.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum count of 9.	RW	***Imp Guide:*** Required if Reason For Service Code (439-E4) is used. ***Payer Requirement:*** Same as Imp Guide.
439-E4	REASON FOR SERVICE CODE	• AT = Additive Toxicity • DC = Drug-Disease (Inferred) • DD = Drug-Drug Interaction • ER = Overuse • HC = High Cumulative Dose • HD = High Dose • LR = Under use • MC = Drug-Disease (Reported) • NS = Insufficient Quantity • PA = Drug-Age • PG = Drug-Pregnancy • SR = Suboptimal Regimen • TD = Therapeutic	RW	***Imp Guide:*** Required if utilization conflict is detected. ***Payer Requirement:*** Same as Imp Guide.
528-FS	CLINICAL SIGNIFICANCE CODE		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing Accepted/Rejected**
				Payer Requirement: Same as Imp Guide.
529-FT	OTHER PHARMACY INDICATOR		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. ***Payer Requirement:*** Same as Imp Guide.
53Ø-FU	PREVIOUS DATE OF FILL		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. ***Payer Requirement:*** Same as Imp Guide.
531-FV	QUANTITY OF PREVIOUS FILL		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. Required if Previous Date of Fill (53Ø-FU) is used. ***Payer Requirement:*** Same as Imp Guide.
532-FW	DATABASE INDICATOR		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. ***Payer Requirement:*** Same as Imp Guide.
533-FX	OTHER PRESCRIBER INDICATOR		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. ***Payer Requirement:*** Same as Imp Guide.
544-FY	DUR FREE TEXT MESSAGE	Information specific to each prospective DUR alert: • AT = (Diagnosis code from history claim indicating side effect)/(history drug name) • DC = (Disease description of contraindication) • DD = (Brand name of drug in history causing alert) • ER = (May Refill on MM/DD/YYYY)	RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. ***Payer Requirement:*** Same as Imp Guide.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing Accepted/Rejected**
		• HC = (Claim MME is XXXXX. Caution.) • HD = (maximum recommended dose is XXX) • LR = (refill is XX days late) • MC = (Disease description of contraindication) • NS = (three month supply opportunity) • PA = (age warning/ contraindication) • PG = (pregnancy contraindication) • SR = (tablet splitting opportunity or dose consolidation opportunity) • TD = (Name of most recent history drug)		
57Ø-NS	DUR ADDITIONAL TEXT		RW	***Imp Guide:*** Required if needed to supply additional information for the utilization conflict. ***Payer Requirement:*** This field contains the drug label names, including any claim in history, causing the prospective DUR alert.

Response Coordination of Benefits/Other Payers Segment Questions	**Check**	**Claim Billing Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent.		
This Segment is situational.	X	This segment informs providers when ForwardHealth has other insurance information for the member/date of service.

	Response Other Payers Segment Segment Identification (111-AM) = "28"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER	• Ø3 = Bank Information Number (BIN) • 99 = Other	RW	***Imp Guide:*** Required if Other Payer ID (34Ø-7C) is used. ***Payer Requirement:*** Same as Imp Guide.

	Response Other Payers Segment Segment Identification (111-AM) = "28"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		Value "99" is the ForwardHealth proprietary other payer ID.		
34Ø-7C	OTHER PAYER ID		RW	***Imp Guide:*** Required if other insurance information is available for coordination of benefits. ***Payer Requirement:*** Same as Imp Guide.
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	***Imp Guide:*** Required if other insurance information is available for coordination of benefits. ***Payer Requirement:*** Same as Imp Guide.
356-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	***Imp Guide:*** Required if other insurance information is available for coordination of benefits. ***Payer Requirement:*** Same as Imp Guide.
992-MJ	OTHER PAYER CARDHOLDER ID		RW	***Imp Guide:*** Required if other insurance information is available for coordination of benefits. ***Payer Requirement:*** Same as Imp Guide.
142-UV	OTHER PAYER PERSON CODE		RW	***Imp Guide:*** Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer. ***Payer Requirement:*** Same as Imp Guide.
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	***Imp Guide:*** Required if needed to provide a support telephone number of the other payer to the receiver. ***Payer Requirement:*** Same as Imp Guide.
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		RW	***Imp Guide:*** Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer. ***Payer Requirement:*** Same as Imp Guide.
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		RW	***Imp Guide:*** Required when other coverage is known which is

	Response Other Payers Segment Segment Identification (111-AM) = "28"			**Claim Billing Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				after the Date of Service submitted. ***Payer Requirement:*** This field will provide other insurance information on file with ForwardHealth for the member/date of service.
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		RW	***Imp Guide:*** Required when other coverage is known which is after the Date of Service submitted. ***Payer Requirement:*** This field will provide other insurance information on file with ForwardHealth for the member/date of service.

Claim Billing Rejected/Rejected Response

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

	Response Transaction Header Segment			**Claim Billing Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	
1Ø9-A9	TRANSACTION COUNT		M	
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

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

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Rejected	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	***Imp Guide:*** Required if needed to identify the transaction. ***Payer Requirement:*** This field contains the authorization number.
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	***Imp Guide:*** Required if a repeating field is in error, to identify repeating field occurrence. This field must be sent when relaying error information about a repeating field or set. *Note:* if the Reject Code is not denoting a repeating field or set, the Reject Field Occurrence Indicator must not be sent. ***Payer Requirement:*** Same as Imp Guide.

B2 CLAIM REVERSAL REQUEST

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	365-days from Date of Service

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	

	Transaction Header Segment			Claim Reversal
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	61Ø499 Ø16929	M	***Payer Requirement:*** Use BIN Number 61Ø499 for all claims except HDAP claims. Use BIN Number Ø16929 for HDAP claims.
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	Enter "WIPARTD" for SeniorCare, Wisconsin Chronic Disease Program (WCDP), and HIV Drug Assistance Program (HDAP) members that are also enrolled in a Medicare Part D Prescription Plan (PDP) to ensure coordination with the TrOOP facilitator.	M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider Identifier (NPI) Ø5 = Medicaid *Note:* "Ø5" is valid for "atypical" providers only.	M	
2Ø1-B1	SERVICE PROVIDER ID	*Note:* "Atypical" providers (i.e., specialized medical vehicle providers, blood banks, and Community Care Organizations) should enter the eight-digit or nine-digit identification number assigned by ForwardHealth.	M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		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) = "Ø4"**			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID	Enter the 1Ø-digit ForwardHealth member identification number.	M	
3Ø1-C1	GROUP ID	TXIX WCDP HDAP	RW	***Imp Guide:*** Required if needed to match the reversal to the original billing transaction. ***Payer Requirement:*** Required. Enter value "TXIX" to indicate Wisconsin Medicaid, BadgerCare Plus, and SeniorCare, "WCDP" to indicate the Wisconsin Chronic Disease Program or "HDAP" to indicate HIV Drug Assistance Program.

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	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	• ØØ = Not Specified • Ø3 = National Drug Code (NDC)	M	
4Ø7-D7	PRODUCT/SERVICE ID		M	

B2 CLAIM REVERSAL RESPONSES

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	

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

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

	Response Message Segment Segment Identification (111-AM) = "2Ø"			**Claim Reversal Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		R	***Imp Guide:*** Required if text is needed for clarification or detail. ***Payer Requirement:*** This field reports a member's remaining spenddown and remaining deductible amounts, regardless of the member's program.

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

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Reversal Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	• A = Approved • S = Duplicate of Approved	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	***Imp Guide:*** Required if needed to identify the transaction.

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Reversal Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: This field contains the Internal Control Number (ICN).

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	
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		M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

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

	Response Message Segment Segment Identification (111-AM) = "2Ø"			Claim Reversal Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		RW	***Imp Guide:*** Required if text is needed for clarification or detail. ***Payer Requirement:*** This field will contain one of the following messages when the claim reversal was not approved: • CLAIM ALREADY REVERSED. • INVALID DISPENSE DATE. • ADJUDICATION DATE OLDER THAN 365 DAYS. • INVALID PROVIDER NUMBER. • CANNOT FIND CLAIM. • MULTIPLE CLAIMS FOUND. • SYSTEM ERROR. • REVERSAL NOT ALLOWED FOR CLAIM STATUS.

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 = Rejected	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	***Imp Guide:*** Required if needed to identify the transaction. ***Payer Requirement:*** This field contains the authorization number.
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	***Imp Guide:*** Required if a repeating field is in error, to identify repeating field occurrence. This field must be sent when relaying error information about a repeating field or set. *Note:* if the Reject Code is not denoting a repeating field or set, the Reject Field Occurrence Indicator must not be sent. ***Payer Requirement:*** Same as Imp Guide.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3 = Processor/PBM	RW	***Imp Guide:*** Required if Help Desk Phone Number (55Ø-8F) is used. ***Payer Requirement:*** Same as Imp Guide.
55Ø-8F	HELP DESK PHONE NUMBER		RW	***Imp Guide:*** Required if needed to provide a support telephone number to the receiver. ***Payer Requirement:*** Same as Imp Guide.

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

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Reversal Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Reversal Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Claim Reversal Rejected/Rejected Response

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

	Response Transaction Header Segment			**Claim Reversal Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT		M	
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

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

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Reversal Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Rejected	M	
5Ø3-F3	AUTHORIZATION NUMBER		RW	***Imp Guide:*** Required if needed to identify the transaction. ***Payer Requirement:*** This field contains the authorization number.
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	

P2 PRIOR AUTHORIZATION REVERSAL

Transaction Header Segment Questions	**Check**	**Prior Authorization 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	

	Transaction Header Segment			**Prior Authorization Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	61Ø499	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider Identifier (NPI) Ø5 = Medicaid *Note:* "Ø5" is valid for "atypical" providers only.	M	
2Ø1-B1	SERVICE PROVIDER ID	*Note:* "Atypical" providers (i.e., specialized medical vehicle providers, blood banks, and Community Care Organizations) should enter the eight-digit or nine-digit identification number assigned by ForwardHealth.	M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		M	

Insurance Segment Questions	**Check**	**Prior Authorization Reversal** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Insurance Segment **Segment Identification (111-AM) = "Ø4"**			**Prior Authorization Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID	Enter the 1Ø-digit ForwardHealth member identification number.	M	

Prior Authorization Segment Questions	**Check**	**Prior Authorization Reversal** If Situational, *Payer Situation*
This Segment is always sent.	X	
This Segment is situational.		

	Prior Authorization Segment **Segment Identification (111-AM) = "12"**			**Prior Authorization Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
498-PA	REQUEST TYPE		M	
498-PB	REQUEST PERIOD DATE-BEGIN		M	
498-PC	REQUEST PERIOD DATE-END		M	
498-PD	BASIS OF REQUEST		M	
498-PY	PRIOR AUTHORIZATION NUMBER-ASSIGNED		RW	***Imp Guide:*** Required if known to sender; otherwise send Authorization Number (5Ø3-F3). ***Payer Requirement:*** Required. Enter the 1Ø-digit prior authorization number assigned by ForwardHealth.

P2 PRIOR AUTHORIZATION REVERSAL RESPONSES

Prior Authorization Reversal Accepted/Approved Response

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

	Response Transaction Header Segment			**Prior Authorization Reversal Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P2	M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

Response Status Segment Questions	**Check**	**Prior Authorization Reversal Accepted/Approved** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Prior Authorization Reversal Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	

Prior Authorization Reversal Accepted/Rejected Response

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

	Response Transaction Header Segment			**Prior Authorization Reversal Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P2	M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

Response Status Segment Questions	**Check**	**Prior Authorization Reversal Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Status Segment **Segment Identification (111-AM) = "21"**			**Prior Authorization Reversal Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Rejected	M	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	

Prior Authorization Reversal Rejected/Rejected Response

Response Transaction Header Segment Questions	**Check**	**Prior Authorization Reversal Rejected/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Transaction Header Segment			**Prior Authorization Reversal Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P2	M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

Response Status Segment Questions	**Check**	**Prior Authorization Reversal Rejected/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Prior Authorization Reversal Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Rejected	M	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	

P3 PRIOR AUTHORIZATION INQUIRY

Transaction Header Segment Questions	**Check**	**Prior Authorization Inquiry** 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	

	Transaction Header Segment			**Prior Authorization Inquiry**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	61Ø499	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider Identifier (NPI) Ø5 = Medicaid *Note:* "Ø5" is valid for "atypical" providers only.	M	
2Ø1-B1	SERVICE PROVIDER ID	*Note:* "Atypical" providers (i.e., specialized medical vehicle providers, blood banks, and Community Care Organizations) should enter the eight-digit or nine-digit identification number assigned by ForwardHealth.	M	
4Ø1-D1	DATE OF SERVICE	Enter the requested start date of the prior authorization request.	M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		M	

Insurance Segment Questions	**Check**	**Prior Authorization Inquiry** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Insurance Segment **Segment Identification (111-AM) = "Ø4"**			**Prior Authorization Inquiry**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID	Enter the 1Ø-digit ForwardHealth member identification number.	M	

Prior Authorization Segment Questions	**Check**	**Prior Authorization Inquiry** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Prior Authorization Segment Segment Identification (111-AM) = "12"			**Prior Authorization Inquiry**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
498-PA	REQUEST TYPE		M	
498-PB	REQUEST PERIOD DATE-BEGIN		M	
498-PC	REQUEST PERIOD DATE-END		M	
498-PD	BASIS OF REQUEST		M	.
498-PY	PRIOR AUTHORIZATION NUMBER-ASSIGNED		RW	***Imp Guide:*** Required if known to sender; otherwise send Authorization Number (5Ø3-F3). ***Payer Requirement:*** Enter the 1Ø-digit prior authorization number assigned by ForwardHealth, if known.

P3 PRIOR AUTHORIZATION INQUIRY RESPONSES

Prior Authorization Inquiry Accepted/Approved Response

Response Transaction Header Segment Questions	**Check**	**Prior Authorization Inquiry Accepted/Approved** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Transaction Header Segment			**Prior Authorization Inquiry Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P3	M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

Response Status Segment Questions	**Check**	**Prior Authorization Inquiry Accepted/Approved** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Prior Authorization Inquiry Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	

Response Claim Segment Questions	**Check**	**Prior Authorization Inquiry Accepted/Approved** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Prior Authorization Inquiry Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response Prior Authorization Segment Questions	**Check**	**Prior Authorization Inquiry Accepted/Approved** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Prior Authorization Segment Segment Identification (111-AM) = "26"			**Prior Authorization Inquiry Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
498-PR	PRIOR AUTHORIZATION PROCESSED DATE		R	
498-PS	PRIOR AUTHORIZATION EFFECTIVE DATE		RW	***Imp Guide:*** Required if the prior authorization has an effective date. ***Payer Requirement:*** Same as Imp Guide.
498-PT	PRIOR AUTHORIZATION EXPIRATION DATE		RW	***Imp Guide:*** Required if the prior authorization has an expiration date. ***Payer Requirement:*** Same as Imp Guide.
498-RA	PRIOR AUTHORIZATION QUANTITY		RW	***Imp Guide:*** Required if the total quantity authorized is greater than zero. ***Payer Requirement:*** This field contains the number of days prior authorized.
498-RB	PRIOR AUTHORIZATION DOLLARS AUTHORIZED		RW	***Imp Guide:*** Required if the total dollars authorized is greater than zero. ***Payer Requirement:*** Same as Imp Guide.
498-PX	PRIOR AUTHORIZATION QUANTITY ACCUMULATED		RW	***Imp Guide:*** Required if the Prior Authorization Quantity (498-RA) is greater than zero. The field must equal the total of the quantities from all claims processed. ***Payer Requirement:*** This field contains the number of days accumulated on the prior authorization.
498-PY	PRIOR AUTHORIZATION NUMBER-ASSIGNED		R	

Prior Authorization Inquiry Accepted/Rejected Response

Response Transaction Header Segment Questions	**Check**	**Prior Authorization Inquiry Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Transaction Header Segment			**Prior Authorization Inquiry Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P3	M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

Response Status Segment Questions	**Check**	**Prior Authorization Inquiry Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Prior Authorization Inquiry Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Rejected	M	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	

Response Claim Segment Questions	**Check**	**Prior Authorization Inquiry Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Prior Authorization Inquiry Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Prior Authorization Inquiry Rejected/Rejected Response

Response Transaction Header Segment Questions	**Check**	**Prior Authorization Inquiry Rejected/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Transaction Header Segment			**Prior Authorization Inquiry Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P3	M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

Response Status Segment Questions	**Check**	**Prior Authorization Inquiry Rejected/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Prior Authorization Inquiry Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Rejected	M	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	

P4 PRIOR AUTHORIZATION REQUEST ONLY

Transaction Header Segment Questions	**Check**	**Prior Authorization Request Only** 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	

	Transaction Header Segment			**Prior Authorization Request Only**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	61Ø499	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P4	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider Identifier (NPI) Ø5 = Medicaid *Note:* "Ø5" is valid for "atypical" providers only.	M	
2Ø1-B1	SERVICE PROVIDER ID	*Note:* "Atypical" providers (i.e., specialized medical vehicle providers, blood banks, and Community Care Organizations) should enter the eight-digit or nine-digit identification number assigned by ForwardHealth.	M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		M	

Insurance Segment Questions	**Check**	**Prior Authorization Request Only** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Insurance Segment **Segment Identification (111-AM) = "Ø4"**			**Prior Authorization Request Only**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID	Enter the 1Ø-digit ForwardHealth member identification number.	M	
312-CC	CARDHOLDER FIRST NAME		RW	***Imp Guide:*** Required if the Patient is the Cardholder, and Date of Birth (3Ø4-C4) is not available.

	Insurance Segment Segment Identification (111-AM) = "Ø4"			**Prior Authorization Request Only**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Note: Cardholder ID (3Ø2-C2) is mandatory. Not used when Cardholder ID (3Ø2-C2), Date of Birth (3Ø4-C4), and Person Code (3Ø3-C3) are present. It is a recommendation that Cardholder ID (3Ø2-C2) and Date of Birth (3Ø4-C4) are used. Required if necessary for state/federal/regulatory agency or Workers' Compensation programs. Required if multiple people have the same Cardholder ID. Required if additional verification of the submitted eligibility information is needed. ***Payer Requirement:*** Required.
313-CD	CARDHOLDER LAST NAME		RW	***Imp Guide:*** Required if the Patient is the Cardholder, and the Date of Birth (3Ø4-C4) is not available. Required if Service Bureau when acting as an agent of sender. Required for presumptive eligibility. Required for coupon/sample/ trial dose programs when there is no unique Cardholder ID. Required if contractually obligated between trading partners. Not used when Cardholder ID (3Ø2-C2), Date of Birth (3Ø4-C4), and Person Code (3Ø3-C3) are present. It is a recommendation that Cardholder ID (3Ø2-C2) and Date of Birth (3Ø4-C4) are used.

	Insurance Segment Segment Identification (111-AM) = "Ø4"			**Prior Authorization Request Only**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Required if necessary for state/federal/regulatory agency or Workers' Compensation programs. Required if multiple people have the same Cardholder ID. Required if additional verification of the submitted eligibility information is needed. ***Payer Requirement:*** Required.
3Ø1-C1	GROUP ID	TXIX WCDP HDAP	RW	***Imp Guide:*** Required if necessary for state/federal/ regulatory agency programs. Required if needed for pharmacy claim processing and payment. ***Payer Requirement:*** Required. Enter value "TXIX" to indicate Wisconsin Medicaid, BadgerCare Plus, and SeniorCare or "WCDP" to indicate Wisconsin Chronic Disease Program or "HDAP" to indicate HIV Drug Assistance Program.

Patient Segment Questions	**Check**	**Prior Authorization Request Only** If Situational, *Payer Situation*
This Segment is always sent.	X	
This Segment is situational.		

	Patient Segment Segment Identification (111-AM) = "Ø1"			**Prior Authorization Request Only**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø7-C7	PLACE OF SERVICE	• Ø1 = Pharmacy • 13 = Assisted Living Facility • 14 = Group Home • 32 = Nursing Facility • 34 = Hospice • 5Ø = Federally Qualified Health Center • 65 = End-Stage Renal Disease Treatment Facility	RW	***Imp Guide:*** Required if this field could result in different coverage, pricing, or patient financial responsibility. ***Payer Requirement:*** Required.

	Patient Segment Segment Identification (111-AM) = "Ø1"			**Prior Authorization Request Only**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		• 72 = Rural Health Clinic		

Claim Segment Questions	**Check**	**Prior Authorization Request Only** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Claim Segment Segment Identification (111-AM) = "Ø7"			**Prior Authorization Request Only**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code (NDC)	M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
442-E7	QUANTITY DISPENSED		R	.
4Ø5-D5	DAYS SUPPLY		R	
415-DF	NUMBER OF REFILLS AUTHORIZED		R	

Prior Authorization Segment Questions	**Check**	**Prior Authorization Request Only** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Prior Authorization Segment Segment Identification (111-AM) = "12"			**Prior Authorization Request Only**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
498-PA	REQUEST TYPE		M	
498-PB	REQUEST PERIOD DATE-BEGIN		M	
498-PC	REQUEST PERIOD DATE-END		M	
498-PD	BASIS OF REQUEST		M	

Prescriber Segment Questions	**Check**	**Prior Authorization Request Only** If Situational, *Payer Situation*
This Segment is always sent.	X	
This Segment is situational.		

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			**Prior Authorization Request Only**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = National Provider Identifier (NPI)	RW	***Imp Guide:*** Required if Prescriber ID (411-DB) is used.

	Prescriber Segment **Segment Identification (111-AM) = "Ø3"**			**Prior Authorization Request Only**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: Same as Imp Guide.
411-DB	PRESCRIBER ID		RW	***Imp Guide:*** Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. ***Payer Requirement:*** Required. Enter the prescriber's NPI.

Clinical Segment Questions	**Check**	**Prior Authorization Request Only** If Situational, *Payer Situation*
This Segment is always sent.	X	
This Segment is situational.		

	Clinical Segment **Segment Identification (111-AM) = "13"**			**Prior Authorization Request Only**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 2.	RW	***Imp Guide:*** Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. ***Payer Requirement:*** Only the first two diagnosis code fields submitted will be processed.
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1 = *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) Ø2 = *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM)	RW	***Imp Guide:*** Required if Diagnosis Code (424-DO) is used. ***Payer Requirement:*** Same as Imp Guide.
424-DO	DIAGNOSIS CODE		RW	***Imp Guide:*** The value for this field is obtained from the prescriber or authorized representative. Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.

	Clinical Segment Segment Identification (111-AM) = "13"			**Prior Authorization Request Only**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/ federal/regulatory agency programs. ***Payer Requirement:*** Required. Enter the primary diagnosis code most relevant to the drug requested for prior authorization. A secondary diagnosis code may also be submitted.

P4 PRIOR AUTHORIZATION REQUEST ONLY RESPONSES

Prior Authorization Request Only Accepted/Captured Response

Response Transaction Header Segment Questions	**Check**	**Prior Authorization Request Only Accepted/Captured** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Transaction Header Segment			**Prior Authorization Request Only Accepted/Captured**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P4	M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

Response Status Segment Questions	**Check**	**Prior Authorization Request Only Accepted/Captured** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Prior Authorization Request Only Accepted/Captured**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	C=Captured	M	
5Ø3-F3	AUTHORIZATION NUMBER	The 1Ø-digit PA number assigned by ForwardHealth.	R	

Response Claim Segment Questions	**Check**	**Prior Authorization Request Only Accepted/Captured** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Prior Authorization Request Only Accepted/Captured**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Prior Authorization Request Only Accepted/Rejected Response

Response Transaction Header Segment Questions	**Check**	**Prior Authorization Request Only Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Transaction Header Segment			**Prior Authorization Request Only Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P4	M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

Response Status Segment Questions	**Check**	**Prior Authorization Request Only Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Prior Authorization Request Only Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Rejected	M	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	***Imp Guide:*** Required if a repeating field is in error, to identify repeating field occurrence. This field must be sent when relaying error information about a repeating field or set. *Note:* if the Reject Code is not denoting a repeating field or set, the Reject Field Occurrence Indicator must not be sent. ***Payer Situation:*** Same as Imp Guide.

Response Claim Segment Questions	**Check**	**Prior Authorization Request Only Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Prior Authorization Request Only Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Prior Authorization Request Only Rejected/Rejected Response

Response Transaction Header Segment Questions	**Check**	**Prior Authorization Request Only Rejected/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Transaction Header Segment			**Prior Authorization Request Only Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	P4	M	
1Ø9-A9	TRANSACTION COUNT	Maximum count of 1.	M	
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER		M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

Response Status Segment Questions	**Check**	**Prior Authorization Request Only Rejected/Rejected** If Situational, *Payer Situation*
This Segment is always sent.	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Prior Authorization Request Only Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Rejected	M	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	***Imp Guide:*** Required if a repeating field is in error, to identify repeating field occurrence. This field must be sent when relaying error information about a repeating field or set. *Note:* if the Reject Code is not denoting a repeating field or set, the Reject Field Occurrence Indicator must not be sent. ***Payer Situation:*** Same as Imp Guide.

APPENDIX A. REVISIONS TO FORWARDHEALTH PAYER SHEET, NCPDP VERSION D.Ø

Payer Sheet Publication Date June 2Ø11

Initial publication of the ForwardHealth Payer Sheet: NCPDP Version D. Ø.

Payer Sheet Publication Date October 2Ø11

TABLE OF CONTENTS

Revised Table of Contents for new pagination.

GENERAL INFORMATION

Revised “Payer Sheet Publication Date” to October, 2Ø11. Revised “Effective as of” date to October 15, 2Ø11.

B1 CLAIM BILLING REQUEST

Revised "Value" column of field 1Ø4-A4 (Processor Control Number) to clarify use of the value "WIPARTD".

Revised "Value" column of field 3Ø8-C8 (Other Coverage Code) to include all values that are accepted by ForwardHealth.

Revised "Value" column of field 429-DT (Special Packaging Indicator) to include all values accepted by ForwardHealth. Updated "Payer Requirement" to clarify use of values "4" and "5".

B1 CLAIM BILLING ACCEPTED/PAID (OR DUPLICATE OF PAID) RESPONSE

Added field 3Ø1-C1 (Group ID) and corresponding "Payer Requirement".

Revised "Payer Requirement" of field 526-FQ (Additional Message Information) to clarify information returned on a duplicate of paid response.

Revised "Value" column of field 544-FY (DUR Free Text Message) for clarification about the message text returned.

B1 CLAIM BILLING ACCEPTED/REJECTED RESPONSE

Revised "Payer Requirement" of field 5Ø4-F4 (Message) to correct typo of Group ID field 3Ø1-C1.

Revised "Value" column and "Payer Requirement" of field 3Ø1-C1 (Group ID) to clarify the information returned in this field.

Revised "Value" column of field 132-UH (Additional Message Information Qualifier) to remove values.

Revised "Value" column of field 526-FQ (Additional Message Information) to remove incorrect information about duplicate claim responses.

Revised "Payer Requirement" column of field 526-FQ (Additional Message Information) to include information about preferred products.

Revised "Value" column of field 4Ø2-D2 (Prescription/Service Reference Number) to remove the value.

Revised "Value" column of field 544-FY (DUR Free Text Message) for clarification about the message text returned.

B2 CLAIM REVERSAL REQUEST

Revised "Value" column of field 1Ø4-A4 (Processor Control Number) to remove incorrect information about value "WIPARTD".

B2 CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE
Removed unused fields 13Ø-UF (Additional Message Information Count), 132-UH (Additional Message Information Qualifier), 526-FQ (Additional Message Information), and 131-UG (Additional Message Information Continuity).

B2 CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE
Revised "Payer Situation" of field 5Ø4-F4 (Message) to include all possible messages.

Removed unused fields 13Ø-UF (Additional Message Information Count), 132-UH (Additional Message Information Qualifier), 526-FQ (Additional Message Information), and 131-UG (Additional Message Information Continuity).

Payer Sheet Publication Date March 2Ø12

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

GENERAL INFORMATION
Revised “Payer Sheet Publication Date” to March 2Ø12. Revised “Effective as of” date to March 9, 2Ø12. Added “NCPDP Emergency Telecommunication External Code List Value Addendum: January 2Ø12”. Revised “Other versions supported:” to None.

B1 CLAIM BILLING ACCEPTED/PAID (OR DUPLICATE OF PAID) RESPONSE
Added field 558-AW (Flat Sales Tax Amount Paid) and corresponding "Payer Requirement".

Added field 559-AX (Percentage Sales Tax Amount Paid) and corresponding "Payer Requirement".

Added field 563-J2 (Other Amount Paid Count) and corresponding "Payer Requirement".

Added field 564-J3 (Other Amount Paid Qualifier) and corresponding "Payer Requirement".

Added field 565-J4 (Other Amount Paid) and corresponding "Payer Requirement".

B2 CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE
Revised “Payer Requirement” column of field 5Ø4-F4 (Message) to include new message, “REVERSAL NOT ALLOWED FOR CLAIM STATUS".

Payer Sheet Publication Date November 2Ø12

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

GENERAL INFORMATION
Revised “Payer Sheet Publication Date” to November, 2Ø12.
Revised “Effective as of” date to November 1, 2Ø12
Revised “NCPDP External Code List Version Date” to: October 2Ø11
Revised “NCPDP Emergency Telecommunication External Code List Value Addendum:” to July 2Ø12

PURPOSE OF PAYER SHEETS
Add “and AIDS/HIV Drug Assistance Program” to list of ForwardHealth Programs

B1 CLAIM BILLING REQUEST
Revised "Value" column of field 1Ø4-A4 (Processing Control Number) to add “and AIDS/HIV Drug Assistance Program members that are also enrolled in a Medicare Part D Prescription Plan (PDP) to ensure coordination with the TrOOP facilitator”.
Revised "Value" column of field 3Ø1-C1 (Group ID) to add the value "ADAP".
Revised "Payer Requirement" of field 3Ø1-C1 (Group ID) to add “or ADAP to indicate AIDS/HIV Drug Assistance Program ".

Revised "Value" column of field 4Ø6-D6 (Compound Code) to add the value "or ADAP".

Revised "Payer Requirement" of field 42Ø -DK (Submission Clarification Code) to add "or ADAP".

Revised "Payer Requirement" of field 461-EU (Pro Authorization Type Code) to add "or ADAP".

Revised "DUR/PPS Segment Questions" to add "This segment is used to bill pharmaceutical care services with dates of service (DOS) before September 1st, 2Ø12".

Revised "Payer Requirement" of field 439-E4 (Reason for Service Code) to add "Required to bill Pharmaceutical Care services with a DOS before September 1st, 2Ø12".

Revised "Payer Requirement" of field 44Ø-E5 (Professional Service Code) to add "Required to bill Pharmaceutical Care services with a DOS before September 1st, 2Ø12".

Revised "Payer Requirement" of field 441-E6 (Result of Service Code) to add "Required to bill Pharmaceutical Care services with a DOS before September 1st, 2Ø12".

Revised "Payer Requirement" of field 474-8E (DUR/PPS Level of Effort) to add "Required to bill Pharmaceutical Care services with a DOS before September 1st, 2Ø12".

Revised "Payer Requirement" of field 474-8E (DUR/PPS Level of Effort) to add the value "or ADAP".

Revised "Compound Segment Questions" to add "or ADAP".

Revised "Clinical Segment Questions" to add "This segment is required to bill pharmaceutical care services with a DOS before September 1st, 2Ø12".

Revised "Clinical Segment Questions" to add "and ADAP".

Revised "Payer Requirement" of field 424-DO (Diagnosis Code) to add "Required to bill Pharmaceutical Care services with a DOS before September 1st, 2Ø12".

Revised "Payer Requirement" of field 424-DO (Diagnosis Code) to add "and ADAP"

B1 Claim Billing Accepted/Paid (or Duplicate of Paid) Response

Revised "Value" column of field 3Ø1-C1 (Group ID) to add the value "WISC_ADAP = AIDS/HIV Drug Assistance Program".

B1 Claim Billing Accepted/Rejected Response

Revised "Value" column of field 3Ø1-C1 (Group ID) to add the value "WISC_ADAP = AIDS/HIV Drug Assistance Program".

B2 Claim Reversal Request

Revised "Value" column of field 1Ø4-A4 (Processing Control Number) to add "and AIDS/HIV Drug Assistance Program (ADAP) members that are also enrolled in a Medicare Part D Prescription Plan (PDP) to ensure coordination with the TrOOP facilitator".

Revised "Value" column of field 3Ø1-C1 (Group ID) to add the value "ADAP".

Revised "Payer Requirement" of field 3Ø1-C1 (Group ID) to add "or ADAP to indicate AIDS/HIV Drug Assistance Program".

P4 Prior Authorization Request Only

Revised "Value" column of field 3Ø1-C1 (Group ID) to add the value "ADAP".
Revised "Payer Requirement" of field 3Ø1-C1 (Group ID) to add "or ADAP to indicate AIDS/HIV Drug Assistance Program".

Payer Sheet Publication Date November 2Ø13

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

GENERAL INFORMATION
Revised “Payer Sheet Publication Date” to November 2Ø13.
Revised “Effective as of” date to November 8, 2Ø13.
Revised “NCPDP External Code List Version Date” to October 2Ø12.
Revised “NCPDP Emergency Telecommunication External Code List Value Addendum” to October 2Ø13.

B1 CLAIM BILLING REQUEST
Revised "Value" column of field 1Ø1-A1 (BIN Number) to add “Ø16929”.

Revised "Payer Requirement" column of field 1Ø1-A1 (BIN Number) to add "Use BIN Number 61Ø499 for all claims except ADAP claims. Use BIN Number Ø16929 for ADAP claims".

Revised “Value” column of field 4Ø8-D8 (Dispense As Written [DAW]/Product Selection Code) to remove “9 = Substitution Allowed By Prescriber, but Plan Requests Brand Patient’s Plan Requested Brand Product To Be Dispensed”.

B2 CLAIM REVERSAL REQUEST
Revised "Value" column of field 1Ø1-A1 (BIN Number) to add “Ø16929”.

Revised "Payer Requirement" column of field 1Ø1-A1 (BIN Number) to add "Use BIN Number 61Ø499 for all claims except ADAP claims. Use BIN Number Ø16929 for ADAP claims"

Payer Sheet Publication Date December 2Ø13

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

GENERAL INFORMATION
Revised “Payer Sheet Publication Date” to December 2Ø13.
Revised “Effective as of” date to December 31, 2Ø13.

B1 CLAIM BILLING REQUEST
Revised "Payer Requirement" column of field 411-DB (Prescriber ID) to read "Required. Providers are required to use the prescriber’s NPI".

Payer Sheet Publication Date October 2Ø14

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

GENERAL INFORMATION
Revised “Payer Sheet Publication Date” to October 2Ø14.
Revised “Effective as of” date to October 12, 2Ø14.
Revised “NCPDP External Code List Version Date” to October 2Ø14.
Payer Sheet Publication Date September 2Ø15

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

GENERAL INFORMATION
Revised “Payer Sheet Publication Date” to September 2Ø15.
Revised “Effective as of” date to September 1, 2Ø15.
NCPDP Emergency Telecommunication External Code List Value Addendum: July 2Ø15

B1 CLAIM BILLING REQUEST
Revised "Value" column of field 492-WE (Diagnosis Code Qualifier) to add “Ø2 = *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM)".

P4 Prior Authorization Request Only
Revised "Value" column of field 492-WE (Diagnosis Code Qualifier) to add “Ø2 = *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM)".

Payer Sheet Publication Date September 2Ø15

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

GENERAL INFORMATION
Revised “Payer Sheet Publication Date” to September 2Ø15.

Payer Sheet Publication Date April 2Ø16

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

GENERAL INFORMATION
Revised “Payer Sheet Publication Date” to April 2Ø16.
Revised “Effective as of” date to April 1, 2Ø16.
NCPDP Emergency Telecommunication External Code List Value Addendum: January 2Ø16

Payer Sheet Publication Date June 2Ø16

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

B1 CLAIM BILLING ACCEPTED/REJECTED RESPONSE
Revised “Payer Sheet Publication Date” to June 2Ø16.

Revised “Effective as of” date to April 11, 2Ø16.

Revised "Value" column of field 544-FY (DUR Free Text Message) for clarification about the message text returned. ER = (XX days of RX remaining) changed to ER = (May Refill on MM/DD/YYYY).

Payer Sheet Publication Date October 2Ø16

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

GENERAL INFORMATION
Revised “Payer Sheet Publication Date” to October 2Ø16.
Revised “Effective as of” date to October 15, 2Ø16.
Revised NCPDP External Code List Version Date: October 2Ø15.

B1 CLAIM BILLING REQUEST
Revised "Value" column for field 1Ø9-A9 (Transaction Count). Maximum count of 4 has been changed to Maximum count of 1.

Payer Sheet Publication Date April 2Ø17

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

GENERAL INFORMATION
Revised "Payer Sheet Publication Date" to April 2Ø17.
Revised "Effective as of" date to April 1, 2Ø17.

B1 CLAIM BILLING REQUEST
Revised "Value" column for field 42Ø-DK (Submission Clarification Code). Added values 2, 20, and 99 to the list of values accepted by ForwardHealth. Added definition for Payer Requirements in the Claim Billing column for values 2, 20, and 99.

Payer Sheet Publication Date October 2Ø17

TABLE OF CONTENTS
Revised Table of Contents for new pagination.

GENERAL INFORMATION
Revised "Payer Sheet Publication Date" to October 2Ø17.
Revised "Effective as of" date to October 15, 2Ø17.
Revised "NCPDP Emergency Telecommunication External Code List Value Addendum" date to April 2Ø17.

Payer Sheet Publication Date February 2Ø18

GENERAL INFORMATION
Revised "Payer Sheet Publication Date" to February 2Ø18.
Revised "Effective as of" date to February 1, 2Ø18.

B1 CLAIM BILLING REQUEST
Revised "Value" column for field 4Ø8-D8 (Dispense as Written [DAW]/Product Selection Code). Deleted values 5 and 8 to the list of values accepted by ForwardHealth.

Payer Sheet Publication Date October 2Ø18

GENERAL INFORMATION
Revised "Payer Sheet Publication Date" to October 2Ø18.
Revised "Effective as of" date to October 15, 2Ø18.
Revised "NCPDP Emergency Telecommunication External Code List Value Addendum" date to July 2Ø18.

B1 CLAIM BILLING RESPONSES
Revised NCPDP Field Name for 557-AV from "TAX EXEMPT INDICATOR" to "PERCENTAGE TAX EXEMPT INDICATOR".
Revised Payer Situation for field 559-AX (Percentage Sales Tax Amount Paid) from "Percentage Sales Tax Basis Paid" to "Percentage Tax Basis Paid".
Revised Segment Identification name "Response Coordination of Benefits/Other Payers" to "Response Other Payers".

Payer Sheet Publication Date October 2Ø19

GENERAL INFORMATION

Revised “Payer Sheet Publication Date” to October 2Ø19.
Revised “Effective as of” date to October 15, 2Ø19.
Revised “NCPDP Emergency Telecommunication External Code List Value Addendum” date to July 2Ø19.

Payer Sheet Publication Date MAY 2Ø2Ø

GENERAL INFORMATION

Revised “Payer Sheet Publication Date” to May 2Ø2Ø.
Revised “Effective as of” date to May 15, 2Ø2Ø.

B1 CLAIM BILLING RESPONSES

Revised "Value" column of field 439-E4 (Reason for Service Code) to add the value "HC = High Cumulative Dose”.
Revised “Value” column of field 544-FY (DUR Free Text Message) to add the value “HC = (Claim MME is XXXXX. Caution.)”.

Payer Sheet Publication Date September 2Ø2Ø

GENERAL INFORMATION

Revised “Payer Sheet Publication Date” to September 2Ø2Ø.
Revised “Effective as of” date to September 21, 2Ø2Ø.

B1 CLAIM BILLING REQUEST

Inserted new row for field 46Ø -ET (Quantity Prescribed).

Payer Sheet Publication Date October 2Ø2Ø

GENERAL INFORMATION

Revised “Payer Sheet Publication Date” to October 2Ø2Ø.
Revised “Effective as of” date to October 12, 2Ø2Ø.

B1 CLAIM BILLING RESPONSES

Revised “Payer Situation” for field 526-FQ (Additional Message Information) of the “Claim Billing Accepted/Paid (or Duplicate of Paid)” column response to indicate remaining spenddown and deductible amounts will report regardless of the member’s program.

Revised “Payer Situation” for field 513-FD (Remaining Deductible Amount) of the “Claim Billing Accepted/Paid (or Duplicate of Paid)” column response to indicate the remaining deductible amount will report regardless of the member’s program.

Revised “Payer Situation” for field 517-FH (Amount Applied to Periodic Deductible) of the “Claim Billing Accepted/Paid (or Duplicate of Paid)” column response to indicate remaining spenddown and deductible amounts will report regardless of the member’s program.

B2 CLAIM REVERSAL RESPONSES

Revised “Payer Situation” for field 5Ø4-F4 (Message) of the “Claim Reversal Accepted/Approved” response to indicate remaining spenddown and deductible amounts will report regardless of the member’s program.

Payer Sheet Publication Date October 2Ø21

GENERAL INFORMATION

Revised “Payer Sheet Publication Date” to October 2Ø21.
Revised “Effective as of” date to October 15, 2Ø21.

Payer Sheet Publication Date October 2Ø22

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GENERAL INFORMATION

Revised “Payer Sheet Publication Date” to October 2Ø22.
Revised “Effective as of” date to October 15, 2Ø22.

Payer Sheet Publication Date October 2Ø23

TABLE OF CONTENTS

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GENERAL INFORMATION

Revised “Payer Sheet Publication Date” to October 2Ø23.
Revised “Effective as of” date to October 15, 2Ø23.

Payer Sheet Publication Date October 2Ø24

TABLE OF CONTENTS

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GENERAL INFORMATION

Revised “Payer Sheet Publication Date” to October 2Ø24.
Revised “Effective as of” date to October 15, 2Ø24.
Revised NCPDP External Code List Version Date: October 2Ø23.

B1 CLAIM BILLING REQUEST

Revised "Payer Situation" for field 411-DB (Prescriber ID) to remove “Payer Requirement: Required. Providers are required to use the prescriber’s NPI".

Revised “Payer Situation” column for “DUR/PPS Segment Questions” to remove “This segment is used to bill pharmaceutical care services with dates of service (DOS) before September 1st, 2012”.

Revised “Payer Situation” for field 439-E4 (Reason for Service Code) to remove “Required to bill pharmaceutical care services with DOS before September 1st, 2012”.

Revised “Payer Situation” for field 440-E5 (Professional Service Code) to remove “Required to bill pharmaceutical care services with DOS before September 1st, 2012”.

Revised “Payer Situation” for field 441-E6 (Result of Service Code) to remove “Required to bill pharmaceutical care services with DOS before September 1st, 2012”.

Revised “Payer Situation” for field 474-8E (DUR/PPS Level of Effort) to remove “bill pharmaceutical care services with DOS before September 1st, 2012, or to”.

Revised “Payer Situation” column for “Clinical Segment Questions” to remove “This segment is required to bill pharmaceutical care services with DOS before September 1st, 2012”.

Revised “Payer Situation” for field 424-DO (Diagnosis Code) to remove “Required to bill pharmaceutical care services with DOS before September 1st, 2012”.

Added field 468-2E (Primary Care Provider ID Qualifier) and corresponding “Payer Requirement".

Added field 421-DL (Primary Care Provider ID) and corresponding “Payer Requirement”.

Payer Sheet Publication Date February 2Ø25

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GENERAL INFORMATION
Revised “Payer Sheet Publication Date” to February 2Ø25.
Revised “Effective as of” date to February 12, 2Ø25.

PURPOSE OF PAYER SHEETS
Replace “AIDS Drug Assistance Program” to “HIV Drug Assistance Program”.

B1 CLAIM BILLING REQUEST

Revised "Payer Requirement" for field 1Ø1-A1 (BIN NUMBER) to replace “ADAP” with “HDAP”.

Revised "Value" for field 1Ø4-A4 (PROCESSOR CONTROL NUMBER) to replace AIDS/HIV Drug Assistance Program (ADAP) with HIV Drug Assistance Program (HDAP).

Revised "Value" for field 3Ø1-C1 (GROUP ID) to replace “ADAP” with “HDAP”.

Revised "Payer Requirement" for field 3Ø1-C1 (GROUP ID) to replace “ADAP” to indicate AIDS/HIV Drug Assistance Program with "HDAP" to indicate HIV Drug Assistance Program.

Revised "Value" for field 4Ø6-D6 (COMPOUND CODE) to replace “ADAP” with “HDAP”.

Revised "Payer Requirement" for field 42Ø-DK (SUBMISSION CLARIFICATION CODE) to replace “ADAP” with “HDAP”.

Revised "Payer Requirement" for field 461-EU (PRIOR AUTHORIZATION TYPE CODE) to replace “ADAP” with “HDAP”.

Revised "Payer Requirement" for field 474-8E (DUR/PPS LEVEL OF EFFORT) to replace “ADAP” with “HDAP”.

Revised “Compound Segment Questions” to replace “ADAP” with “HDAP”.

Revised “Clinical Segment Questions” to replace “ADAP” with “HDAP”.

Revised "Payer Requirement" for field 424-DO (DIAGNOSIS CODE) to replace “ADAP” with “HDAP”.

B1 CLAIM BILLING RESPONSES

Claim Billing Accepted/Paid (or Duplicate of Paid) Response
Revised "Value" for field 3Ø1-C1 (GROUP ID) to replace “ADAP = AIDS/HIV Drug Assistance Program” with “HDAP = HIV Drug Assistance Program”.

Claim Billing Accepted/Rejected Response

Revised "Value" for field 3Ø1-C1 (GROUP ID) to replace “ADAP = AIDS/HIV Drug Assistance Program” with “HDAP = HIV Drug Assistance Program”.

B2 CLAIM REVERSAL REQUEST

Revised "Payer Requirement" for field 1Ø1-A1 (BIN NUMBER) to replace “ADAP” with “HDAP”.

Revised "Value" for field 1Ø4-A4 (PROCESSOR CONTROL NUMBER) to replace “AIDS/HIV Drug Assistance Program (ADAP)” with “HIV Drug Assistance Program (HDAP)”.

Revised "Value" for field 3Ø1-C1 (GROUP ID) to replace “ADAP” with “HDAP”.

Revised "Payer Requirement" for field 3Ø1-C1 (GROUP ID) to replace “ADAP” to indicate AIDS/HIV Drug Assistance Program with "HDAP" to indicate HIV Drug Assistance Program.

P4 PRIOR AUTHORIZATION REQUEST ONLY

Revised "Value" for field 3Ø1-C1 (GROUP ID) to replace “ADAP” with “HDAP”.

Revised "Payer Requirement" for field 3Ø1-C1 (GROUP ID) to replace “ADAP” to indicate AIDS/HIV Drug Assistance Program with "HDAP" to indicate HIV Drug Assistance Program.

Payer Sheet Publication Date October 2Ø25

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GENERAL INFORMATION

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