

Medicare's Limited Income NET Program  
(LINET)

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**GENERAL INFORMATION**

Payer Name: Medicare's Limited Income NET Program (LINET)	Date: 08/04/2020	
Plan Name/Group Name: Medicare's Limited Income NET Program (LINET)	BIN: 015599	PCN:05440000
Plan Name/Group Name:	BIN:	PCN:
Plan Name/Group Name:	BIN:	PCN:
Plan Name/Group Name:	BIN:	PCN:
Processor: SS&C Health. – All claims are to be routed through Relay Health.		
Effective as of: 09/21/2020	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: July, 2007	NCPDP External Code List Version Date: March, 2010	
Contact/Information Source: 1-800-783-1307		
Certification Testing Window: Certification Not Required.		
Certification Contact Information: Certification Not Required.		
Provider Relations Help Desk Info: 1-800-783-1307		
Other versions supported:		

**OTHER TRANSACTIONS SUPPORTED**

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

Transaction Code	Transaction Name
B2	Reversal
B3	Rebill

# Medicare's Limited Income NET Program (LINET)

## General Processing Notes

Pharmacy providers in good standing with a valid NPI number, regardless of their Network status with Humana, are permitted to submit claims under this Medicare program.

### **Timely Filing Limits**

Timely Filing Limits are the deadlines by which a request for claims payment under Medicare's Limited Income NET Program (LINET) shall be made to the Contractor to qualify for payment. The Timely Filing Limit varies by population, as follows:

- **Point-of-Sale (POS) Individuals – Individuals who have claims paid via the LINET Program at POS (i.e., not already enrolled in a Part D plan)**
  - Individuals who have Medicare and full Medicaid (Full-Benefit Dual Eligibles), or have Medicare and receive Supplemental Security Income (SSI-Only Eligibles) and have proof of Medicare's Low-Income Subsidy (LIS), or "Extra Help" in Medicare's systems
    - Request for payment via POS must be made within **36 months of the Date of Service**; however, claims greater than 30 days old will initially be rejected with instruction to contact the LINET Program at **1-800-783-1307** for an eligibility determination before submitting claim
  - Individuals who have Medicare and partial Medicaid (Partial-Benefit Dual Eligibles) or those that have been awarded LIS (LIS Applicants) and have proof of LIS eligibility in Medicare's systems
    - Request for payment via POS must be made within **30 days of the Date of Service**

Once individuals have had claims paid via the LINET Program at the Point of Sale, their eligibility will be validated and they will be enrolled in the LINET Part D prescription drug plan with timely filing limits as shown below. All individuals who are enrolled in the LINET Program will continue to receive coverage under this program for up to two (2) months until Medicare enrolls them into another Part D prescription drug plan.

- **Enrollees (individuals who have been automatically enrolled by Medicare in the LINET Program)**
  - Enrollees may be automatically enrolled by Medicare or enrolled via the POS method above
  - Prior authorization is required for claims submitted more than 36 months after the Date of Service, even during a period of LINET enrollment (contact the LINET Program at **1-800-783-1307**)
  - After disenrollment from the LINET Program, request for payment must be submitted within **180 days after** the date of disenrollment from the LINET Program

### **Billing for Enrollees**

The LINET Program is a Medicare program operated by Humana. If the pharmacy provider executes an E1 query to Medicare's online eligibility and enrollment verification system, called the TrOOP Facilitator, and determines that a beneficiary is already enrolled in the LINET Program, it can use the same submission requirements as stated in this Payer Sheet to submit claims for that enrollee. Cardholder ID can be submitted with either:

- the beneficiary's Medicare Number (on the red, white and blue Medicare card) or
- the LINET Cardholder ID as returned on the E1 response or found on an enrollee's confirmation of enrollment letter

Pharmacy providers should be aware that the beneficiary's enrollment in the LINET Program is for a limited period of time only, and the pharmacy should submit an E1 query each new month to determine when the beneficiary has been enrolled into a different Part D prescription drug plan.

**Please Note:** Effective January 1, 2020 to submit an LINET claim, you must submit the claim using the beneficiaries Medicare Beneficiary Identifier (MBI).

## **IMMEDIATE NEED**

Immediate need override can be given if the pharmacist has indicated that the beneficiary is in immediate need and has three days supply or less of their medication. Contact the LINET Helpdesk at 1-800-783-1307 for assistance.

Paper claims for enrollees in the LINET Program can be mailed to the following address and should be submitted using the standard National Council for Prescription Drug Programs (NCPDP) Universal Claim Form format.

### **Medicare's Limited Income NET Program (LINET)**

**PO BOX 14310**

**Lexington, KY 40512-4310**

### **Rejection Edits that will be Applied**

In addition to existing edits, the following contract-specific edits will be applied to all claims submitted under this Program:

- Therapy Duplication on certain drugs
- Quantity that exceeds Maximum dosage by more than two times the First Data Bank (FDB) guidelines
- Refill Too Soon
- Medicare Part D Excluded Drugs
- Claims with a Total Rx Cost greater than \$2,500 (prior authorization is required)
- Non-Network claims with a Usual and Customary amount that exceeds a reasonable threshold of \$600 (prior authorization required)
- "No LIS on CMS' systems. If proof of LIS or Medicaid available, call 800-783-1307"
- Days supply limitations
  - Opioids, Benzodiazepines and Hepatitis C drugs are limited to a 30 days supply
  - All other drugs are limited to a 60 days supply.
- Package size limitation for certain medications
  - Quantity submitted exceeds 3x the NDC package size. Claim can be submitted with a lower quantity or communicate to the prescriber that a prior authorization is required for the written amount

Pharmacy providers that believe a claim is valid despite one of these rejection edits should call **1-800-783-1307** to request an override.

### **Requesting an Eligibility Review**

An individual can request an eligibility review by contacting **1- 800-783-1307** if he/she had a claim denied at the pharmacy or received a letter indicating ineligibility for the LINET Program. A representative from the LINET Program will conduct an eligibility review to determine if claims should be paid on behalf of the individual. Below you will find examples of proof that the individual can use to verify his/her Medicaid or LIS eligibility.

- A letter from Medicare or the Social Security Administration (SSA) showing the individual qualifies for the LIS, or "Extra Help."
  - If the individual automatically qualifies for "Extra Help," he/she should have received a purple, yellow or green letter from Medicare that can be sent by mail or facsimile to the LINET Program as proof that he/she qualifies.
  - If the individual applied for, and was awarded, "Extra Help," he/she can send the "Notice of Award" from SSA by mail or facsimile to the LINET Program as proof that he/she qualifies.

- Verification received from a Medicare caseworker
- Verification received from a state or county Medicaid staff person
- The individual can also send any of the following documents as proof that he/she qualifies for Medicaid. Each item listed below must show that the individual was eligible for Medicaid on the date of service of the claim.
  - A copy of the individual's Medicaid card
  - A copy of a state document that shows the individual has Medicaid
  - A printout from a state electronic enrollment file or screen print from the individual's state Medicaid systems that shows he/she has Medicaid
  - Proof the individual has Medicaid and lives in an institution
  - A bill from an institution (like a nursing home) or a copy of a state document showing Medicaid payment to the institution for at least a month
  - A screen print from the individual's state Medicaid systems showing that he/she lived in an institution for at least a month

Any documentation submitted will be reviewed. Documentation can be faxed to Humana at **1-877-210-5592** or mailed to the following address. If documentation shows that the individual qualifies for the LINET Program, claims will be paid on his/her behalf by Humana's claims processor, SS&C Health

**Medicare's Limited Income NET Program**

**PO BOX 14310**

**Lexington, KY 40512-4310**

Pharmacy help desk hours of operation: 24 hours a day, 7 days a week, 365 days a year

Customer Service hours of operation: Monday-Friday 8 a.m. to 11 p.m. TTY users should call: 771.

This information may be available in a different format, including Spanish, large print, and audio tapes. Please call Customer Service at 1-800-783-1307 (Calls to these numbers are free.)

TTY users call: 711 - above if you need plan information in another format or language.

Esta información puede estar disponible en otro formato, incluyendo en inglés, en letra grande o en cintas de audio. Si necesita información del plan en otro idioma o en otro formato, llame al Servicio al Cliente al número que aparece anteriormente.

### **Additional Information for Vaccine Administration Billing**

**Vaccine Administration** claims may be submitted by all pharmacies, regardless of their Network status. All claims for vaccine administration must meet the following criteria in addition to all existing claim edits: the Product/Service ID (407-D7) must be for a covered Part D vaccine, the Incentive Amount Submitted (438-E3) must be greater than zero and the Professional Service Code (440-E5) of “MA” is required. For Network pharmacies, the pharmacy must also have a contracted administration fee on file with Humana.

Vaccine claims without an Incentive Amount Submitted (438-E3) greater than zero and without a PPS Professional Service Code (440-E5) of “MA” will process as a drug dispensing only claim and will not reimburse an Administrative Fee.

If a claim is submitted for a valid Part D vaccine drug and the incentive amount submitted (438-E3) is greater than zero, but no PPS Professional Service Code (440-E5) of “MA” was submitted, the claim will reject with Reject Code (511-FB) of “R0” and Additional Message Information (526-FQ) of “PROF SVC CODE REQD FOR VACCINE INC FEE.”

If a claim is submitted for a valid Part D vaccine drug and the incentive amount submitted is zero or the incentive amount is not submitted, the and PPS Professional Service Code “MA” is submitted, the claim will reject with Reject Code (511-FB) of “E3” and Additional Message Information (526-FQ) of “NON 0 VALUE REQD FOR VACCINE ADMIN.”

**NOTE:** The Incentive Amount Submitted (438-E3) must be greater than zero when a PPS Professional Service Code (440-E5) is submitted.

### **Additional Information for Vaccine Administration Claim Response**

If a valid Part D vaccine drug and an incentive amount submitted (438-E3) is sent, but PPS Professional Service Code (440-E5) of “MA” was not submitted, the claim will reject with error code E5 and additional message information (526-FQ) of PROF SVC CODE REQD FOR VACCINE INC FEE.

If valid Part D vaccine drug and incentive amount submitted (438-E3) is zero or that field is not submitted and PPS Professional Service Code (440-E5) of “MA” is submitted, the claim will reject with reject code E3 and additional message information (526-FQ) of NON 0 VALUE REQD FOR VACCINE ADMIN.

# NCPDP VERSION D Claim Billing/Claim Rebill Template

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

## GENERAL INFORMATION

Payer Name: <b>Medicare's Limited Income NET Program (LINET)</b>	Date: <b>08/04/2020</b>	
Plan Name/Group Name: <b>Medicare's Limited Income NET Program (LINET)</b>	BIN: <b>015599</b>	PCN: <b>05440000</b>
Plan Name/Group Name:	BIN:	PCN:
Plan Name/Group Name:	BIN:	PCN:
Plan Name/Group Name:	BIN:	PCN:
Processor: <b>SS&amp;C Health – All claims are to be routed through Relay Health.</b>		
Effective as of: <b>09/21/2020</b>	NCPDP Telecommunication Standard Version/Release #: <b>D.0</b>	
NCPDP Data Dictionary Version Date: <b>July, 2007</b>	NCPDP External Code List Version Date: <b>March, 2010</b>	
Contact/Information Source: <b>1-800-783-1307</b>		
Certification Testing Window: <b>Certification Not Required.</b>		
Certification Contact Information: <b>Certification Not Required.</b>		
Provider Relations Help Desk Info: <b>1-800-783-1307</b>		
Other versions supported:		

## OTHER TRANSACTIONS SUPPORTED

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

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

## FIELD LEGEND FOR COLUMNS

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

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

## CLAIM BILLING/CLAIM REBILL TRANSACTION

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

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

	Transaction Header Segment			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN NUMBER	015599	M	
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	B1 = Billing (claim)
104-A4	PROCESSOR CONTROL NUMBER	05440000	M	Valid PCN required.
109-A9	TRANSACTION COUNT	1	M	Only 1 transaction for transmissions for Medicare Part D claims.
202-B2	SERVICE PROVIDER ID QUALIFIER	01	M	Only value '01' (NPI) accepted.
201-B1	SERVICE PROVIDER ID		M	NPI of pharmacy
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	601DN30Y	M	601DN30Y

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

	Insurance Segment Segment Identification (111-AM) = "04"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	Submit beneficiary's MBI as it appears on the beneficiary's Medicare card, or the Cardholder ID indicated on a corresponding Eligibility Verification transaction (E1) response
997-G2	CMS PART D DEFINED QUALIFIED FACILITY	Y Yes=CMS qualified facility N No=Not a CMS qualified facility	RW	Imp Guide: Required if specified in trading partner agreement.  Payer Requirement: Required for Medicare Part D Long Term Care (LTC) claim submission. This includes ICF/MR-IMD as they are defined by CMS as LTC.

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

	Patient Segment Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
331-CX	PATIENT ID QUALIFIER	99 = Other - Different from those	RW	Imp Guide: Required if Patient ID (332-CY) is used.

	Patient Segment Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
		implied or specified.		Payer Requirement: (Same as Imp Guide).
332-CY	PATIENT ID		RW	Imp Guide: Required if necessary for state/federal/regulatory agency programs to validate dual eligibility.  Payer Requirement: Submit Medicaid ID. If not available, submit SSN if provided. If neither Medicaid ID nor SSN is provided, field is not required.
304-C4	DATE OF BIRTH		R	
305-C5	PATIENT GENDER CODE		R	
310-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	
307-C7	PLACE OF SERVICE		RW	Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility Payer Requirement: Required for Medicare Part D Long Term Care (LTC) claim submission. Required when submitting HIT, LTC (ICF/MR-IMD and ALF claims) should always be 01.
322-CM	PATIENT STREET ADDRESS		R	
323-CN	PATIENT CITY ADDRESS		R	
324-CO	PATIENT STATE / PROVINCE ADDRESS		R	
325-CP	PATIENT ZIP/POSTAL ZONE		R	
326-CQ	PATIENT PHONE NUMBER		R	
384-4X	PATIENT RESIDENCE	1 = Community/Retail Pharmacy Services 2 = Compounding Pharmacy Services 3 = Home Infusion Therapy Provider Services 4 = Institutional Pharmacy Services 5 = Long Term Care Pharmacy Services 6 = Mail Order Pharmacy Services 7 = Managed Care Organization Pharmacy Services 8 = Specialty Care Pharmacy Services 99=Other	R	Imp Guide: Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer.  Payer Requirement: Required for all Part D claims effective 1/1/2014.

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



	Claim Segment Segment Identification (111-AM) = “07”			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing - Transaction is a billing for a prescription or OTC drug product	M	<i>Imp Guide:</i> For Transaction Code of “B1”, in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	00 – Not Specified 03-National Drug Code (NDC)	M	00 = Multi-Ingredient Compound billing
407-D7	PRODUCT/SERVICE ID	0 = If Compound, otherwise 11 digit NDC	M	
442-E7	QUANTITY DISPENSED		R	
403-D3	FILL NUMBER	0 = Original dispensing – The first dispensing 1-99 = Refill number – Number of the replenishment	R	
405-D5	DAYS SUPPLY		R	
406-D6	COMPOUND CODE	0 = Not Specified 1 = Not a Compound—Medication that is available commercially as a dispensable product 2 = Compound – Customized medication prepared in a pharmacy by combining, mixing, or altering of ingredients (but not reconstituting) for an individual patient in response to a licensed practitioner’s prescription	R	
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED	0 = No refills authorized 1-99 = Authorized Refill number - with 99 being as needed, refills	RW	<i>Imp Guide:</i> Required if necessary for plan benefit administration.  <i>Payer Requirement: (Same as Imp Guide).</i>
419-DJ	PRESCRIPTION ORIGIN CODE		RW	<i>Imp Guide:</i> Required if necessary for plan benefit administration.  <i>Payer Requirement: Required for Medicare Part D claim processing. Required on original Rx. When Fill Number is ‘0’ (Original Prescription), the POC requires a value of 1 – 5. Optional on refill Rx. When Fill Number is 01 – 99 (Refill Prescription), the POC may be submitted with values of 1 – 5. Note: POC editing for Original Rx varies by customer. If claim denies, will return NCPDP Reject Code ‘33’ (M/I Prescription)</i>

	Claim Segment Segment Identification (111-AM) = “Ø7”			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Origin Code).
460-ET	QUANTITY PRESCRIBED		RW	<p><i>Imp Guide*</i> : Required when the transmission is for a Schedule II drug as defined in 21 CFR 1308.12 and per CMS-0055-F (Compliance Date 9/21/2020. Refer to the Version D.0 Editorial Document).</p> <p><i>Payer Requirement:</i> .</p> <ul style="list-style-type: none"> <li>• Effective 09/21/2020, field is required for Schedule II drugs</li> </ul>
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3	RW	<p><i>Imp Guide:</i> Required if Submission Clarification Code (42Ø-DK) is used.</p> <p><i>Payer Requirement:</i> (Same as <i>Imp Guide</i>).</p>
42Ø-DK	SUBMISSION CLARIFICATION CODE		RW	<p><i>Imp Guide:</i> Required if clarification is needed and value submitted is greater than zero (Ø).</p> <p>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.</p> <p><i>Payer Requirement:</i> Same as <i>Imp Guide</i></p> <p>An applicable LTC Appropriate Dispensing claim must have Patient Residence equal to 03, and the appropriate Submission Clarification Code and Special Package Indicator value combinations for brand oral solid drugs.</p>
3Ø8-C8	OTHER COVERAGE CODE		RW	<p><i>Imp Guide:</i> Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers.</p> <p>Required for Coordination of Benefits.</p> <p><i>Payer Requirement:</i> (Same as <i>Imp Guide</i>).</p> <p>A value in this field communicates instances of other payer consideration of the claim.</p> <p>Note: Due to the Medicare True out-of-pocket (TrOOP) requirements, “copay only billing” (Other Coverage Code = 8) should not be used.</p>
429-DT	SPECIAL PACKAGING INDICATOR		RW	<p><i>Payer Requirement:</i> To be used in conjunction with 384-4X- Patient Residence and 420-DK – Submission Clarification Code for Medicare Part D Long Term Care (LTC) Appropriate Dispensing.</p> <p>An applicable LTC Appropriate Dispensing claim must have Patient Residence equal to 03, and the appropriate Submission Clarification Code and Special Package Indicator value combinations for brand oral solid drugs.</p>

	Claim Segment Segment Identification (111-AM) = “07”			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
461-EU	PRIOR AUTHORIZATION TYPE CODE		RW	Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility.  Payer Requirement: (Same as Imp Guide).
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility.  Payer Requirement: Required when prior authorization number is issued.
147-U7	PHARMACY SERVICE TYPE	1 = Community/Retail Pharmacy Services 2 = Compounding Pharmacy Services 3 = Home Infusion Therapy Provider Services 4 = Institutional Pharmacy Services 5 = Long Term Care Pharmacy Services 6 = Mail Order Pharmacy Services 7 = Managed Care Organization Pharmacy Services 8 = Specialty Care Pharmacy Services 99=Other	R	Imp Guide: Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer.  Payer Requirement: Required for all Part D claims effective 1/1/2014.
Pricing Segment Questions		Check	Claim Billing/Claim Rebill If Situational, Payer Situation	
This Segment is always sent		X		

	Pricing Segment Segment Identification (111-AM) = “11”			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	INGREDIENT COST SUBMITTED		R	Imp Guide: Required if this value is used to arrive at the final reimbursement.  Payer Requirement: If cost submitted is over \$2500 Prior Authorization is required.
412-DC	DISPENSING FEE SUBMITTED		R	
433-DX	PATIENT PAID AMOUNT SUBMITTED		R	
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	Imp Guide: Required if its value has an effect on the Gross Amount Due (430-DU) calculation.  Payer Requirement: (Same as Imp Guide) Vaccine Billing – Amount can be greater than \$0.00, if so, then 440-E5 (Professional Service Code) must equal “MA”.

	Pricing Segment Segment Identification (111-AM) = “11”			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.  <i>Payer Requirement: (Same as Imp Guide).</i>
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		RW	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted (480-H9) is used.  <i>Payer Requirement: (Same as Imp Guide).</i>
480-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (430-DU) calculation.  <i>Payer Requirement: (Same as Imp Guide).</i>
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (430-DU) calculation.  <i>Payer Requirement: (Same as Imp Guide).</i>
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (430-DU) calculation.  <i>Payer Requirement: Same as Imp Guide</i>
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		RW	<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used.  Required if this field could result in different pricing.  Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).  <i>Payer Requirement: Same as Imp Guide</i>
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		RW	<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used.  Required if this field could result in different pricing.  Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).  <i>Payer Requirement: Same as Imp Guide</i>
426-DQ	USUAL AND CUSTOMARY CHARGE		R	Payer Requirement: <b>For \$0.00 claims, must be populated with \$0.00 and equal to Gross Amt Due field, 430-DU.</b>
430-DU	GROSS AMOUNT DUE		R	Payer Requirement: <b>For \$0.00 claims, must be populated with \$0.00 and equal to Usual and Customary Charge, field 426-DQ.</b>

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

	Prescriber Segment Segment Identification (111-AM) = “03”			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

	<b>Prescriber Segment Segment Identification (111-AM) = “03”</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
466-EZ	PRESCRIBER ID QUALIFIER	01 – NPI	R	<i>Imp Guide:</i> Required if Prescriber ID (411-DB) is used.  <i>Payer Requirement:</i> (Same as Imp Guide).
411-DB	PRESCRIBER ID		R	<i>Imp Guide:</i> Required if this field could result in different coverage or patient financial responsibility.  Required if necessary for state/federal/regulatory agency programs.  <i>Payer Requirement:</i> Prescriber NPI required.

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

If the Payer supports the Coordination of Benefits/Other Payments Segment, only one scenario method shown above may be supported per template. The template shows the Coordination of Benefits/Other Payments Segment that must be used for each scenario method. The Payer must choose the appropriate scenario method with the segment chart, and delete the other scenario methods with their segment charts. See section [Coordination of Benefits \(COB\) Processing](#) for more information.

	<b>Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = “05”</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
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		RW	<i>Imp Guide:</i> Required if Other Payer ID (340-7C) is used.  <i>Payer Requirement:</i> (Same as Imp Guide).
340-7C	OTHER PAYER ID		RW	<i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication.  <i>Payer Requirement:</i> (Same as Imp Guide). Submission of 015599 or 015581 will result in claim being rejected.
443-E8	OTHER PAYER DATE		RW	<i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.  <i>Payer Requirement:</i> (Same as Imp Guide).
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used.  <i>Payer Requirement:</i> (Same as Imp Guide).
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER		RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = “05”			Claim Billing/Claim Rebill Scenario 1 - Other Payer Amount Paid Repetitions Only
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				(431-DV) is used.  <i>Payer Requirement: Required when 431-DV is submitted.</i> A value of “08” is only used to indicate total reimbursement from the other payer. Segments submitted with “08” cannot have additional Other Payer Amount Paid fields (431-DV) submitted.
431-DV	OTHER PAYER AMOUNT PAID		RW	<i>Imp Guide:</i> Required if other payer has approved payment for some/all of the billing.  Not used for patient financial responsibility only billing.  Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted.  <i>Payer Requirement: Any dollar amount can be submitted and claim will NOT reject.</i> If dollar amount sent is less than \$0.00, this will be treated as \$0.00 and used in any pricing calculations. A Free Form message will be returned of “Negative \$ in 431-DV; Used as a 0\$ Amount.”
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used.  <i>Payer Requirement: (Same as Imp Guide).</i>
472-6E	OTHER PAYER REJECT CODE		RW	<i>Imp Guide:</i> Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (308-C8) = 3 (Other Coverage Billed – claim not covered).  <i>Payer Requirement: (Same as Imp Guide).</i>

DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	To be submitted if additional information is needed.

	DUR/PPS Segment Segment Identification (111-AM) = “08”			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	<i>Imp Guide:</i> Required if DUR/PPS Segment is used.  <i>Payer Requirement: (Same as Imp Guide).</i>
440-E5	PROFESSIONAL SERVICE CODE		RW	<i>Imp Guide:</i> Required if this field could result in

	DUR/PPS Segment Segment Identification (111-AM) = “08”			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement: (Same as Imp Guide) Vaccine Billing – MA and incentive fee (438-E3) can be submitted, if needed.</i> 441-E6 RESULT OF SERVICE CODE RW <i>Imp Guide: Required if this field could.</i>
441-E6	RESULT OF SERVICE CODE		RW	<i>Imp Guide: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.</i>  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement: (Same as Imp Guide)</i>

Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	To be sent if claim is for a compound.

	Compound Segment Segment Identification (111-AM) = “10”			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	.
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER		M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		RW	<i>Imp Guide: Required if needed for receiver claim determination when multiple products are billed.</i>  <i>Payer Requirement: (Same as Imp Guide).</i>
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION		RW	<i>Imp Guide: Required if needed for receiver claim determination when multiple products are billed.</i>  <i>Payer Requirement: (Same as Imp Guide).</i>

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

# Response Claim Billing/Claim Rebill Payer Sheet

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

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

### GENERAL INFORMATION

Payer Name: <b>Medicare's Limited Income NET Program (LINET)</b>	Date: <b>08/04/2020</b>	
Plan Name/Group Name: <b>Medicare's Limited Income NET Program (LINET)</b>	BIN: <b>015599</b>	PCN: <b>05440000</b>

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

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

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

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

Response Insurance Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	<b>X</b>	Used to provide Network Reimbursement ID when needed.

	Response Insurance Segment Segment Identification (111-AM) = "25"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
301-C1	GROUP ID			<i>Imp Guide:</i> Required if needed to identify the actual cardholder or employer group, to identify appropriate group number, when available.  Required to identify the actual group that was used when multiple group coverages exist.  <i>Payer Requirement:</i> (Same as Imp Guide).



	Response Insurance Segment Segment Identification (111-AM) = “25”			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
545-2F	NETWORK REIMBURSEMENT ID		RW	<p><i>Imp Guide:</i> Required if needed to identify the network for the covered member.</p> <p>Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available.</p> <p>Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>

Response Patient Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Returned when any of the field data is known.

	Response Patient Segment Segment Identification (111-AM) = “29”			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME		RW	<p><i>Imp Guide:</i> Required if known.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
311-CB	PATIENT LAST NAME		RW	<p><i>Imp Guide:</i> Required if known.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
304-C4	DATE OF BIRTH		RW	<p><i>Imp Guide:</i> Required if known.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>

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

	Response Status Segment Segment Identification (111-AM) = “21”			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
503-F3	AUTHORIZATION NUMBER		RW	<p><i>Imp Guide:</i> Required if needed to identify the transaction.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5	RW	<p><i>Imp Guide:</i> Required if Approved Message Code (548-6F) is used.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
548-6F	APPROVED MESSAGE CODE		RW	<p><i>Imp Guide:</i> Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

	Response Status Segment Segment Identification (111-AM) = “21”			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> (Same as Imp Guide). Note: Current NCPDP and SS&C Health count supported = maximum of 9.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> (Same as Imp Guide).
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> (Same as Imp Guide).
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.  <i>Payer Requirement:</i> (Same as Imp Guide)
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used.  <i>Payer Requirement:</i> (Same as Imp Guide).
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.  <i>Payer Requirement:</i> (Same as Imp Guide). Note: Help Desk Phone Number may continue to be returned in 526-FQ Additional Message Information field.

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

	Response Claim Segment Segment Identification (111-AM) = “22”			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	<i>Imp Guide:</i> For Transaction Code of “B1”, in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (RxBilling).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

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

	Response Pricing Segment Segment Identification (111-AM) = “23”			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	

	Response Pricing Segment Segment Identification (111-AM) = "23"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
507-F7	DISPENSING FEE PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.  <i>Payer Requirement:</i> (Same as Imp Guide).
558-AW	FLAT SALES TAX AMOUNT PAID		RW	<i>Imp Guide:</i> Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (Ø) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement.  <i>Payer Requirement:</i> (Same as Imp Guide).
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.  Required if Percentage Sales Tax Amount Submitted (482-GE) is greater than zero (Ø).  Required if Percentage Sales Tax Rate Paid (560-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used.  <i>Payer Requirement:</i> (Same as Imp Guide).
560-AY	PERCENTAGE SALES TAX RATE PAID		RW	<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).  <i>Payer Requirement:</i> (Same as Imp Guide).
561-AZ	PERCENTAGE SALES TAX BASIS PAID		RW	<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).  <i>Payer Requirement:</i> (Same as Imp Guide).
521-FL	INCENTIVE AMOUNT PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.  Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø).  <i>Payer Requirement:</i> (Same as Imp Guide).
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used.  <i>Payer Requirement:</i> (Same as Imp Guide).
564-J3	OTHER AMOUNT PAID QUALIFIER		RW	<i>Imp Guide:</i> Required if Other Amount Paid (565-J4) is used.  <i>Payer Requirement:</i> (Same as Imp Guide).
565-J4	OTHER AMOUNT PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.  Required if Other Amount Claimed Submitted (480-H9) is greater than zero (Ø).  <i>Payer Requirement:</i> (Same as Imp Guide).
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.  Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.  <i>Payer Requirement:</i> (Same as Imp Guide).
509-F9	TOTAL AMOUNT PAID		R	

	Response Pricing Segment Segment Identification (111-AM) = “23”			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		RW	<i>Imp Guide:</i> Required if Ingredient Cost Paid (506-F6) is greater than zero (0).  Required if Basis of Cost Determination (432-DN) is submitted on billing.  <i>Payer Requirement: (Same as Imp Guide).</i>
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT		RW	<i>Imp Guide:</i> Provided for informational purposes only.  <i>Payer Requirement: (Same as Imp Guide).</i>
513-FD	REMAINING DEDUCTIBLE AMOUNT		RW	<i>Imp Guide:</i> Provided for informational purposes only.  <i>Payer Requirement: (Same as Imp Guide).</i>
514-FE	REMAINING BENEFIT AMOUNT		RW	<i>Imp Guide:</i> Provided for informational purposes only.  <i>Payer Requirement: (Same as Imp Guide).</i>
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes deductible  <i>Payer Requirement: (Same as Imp Guide).</i>
518-FI	AMOUNT OF COPAY		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes copay as patient financial responsibility.  <i>Payer Requirement: (Same as Imp Guide).</i>
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes amount exceeding periodic benefit maximum.  <i>Payer Requirement: (Same as Imp Guide).</i>
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE		RW	<i>Imp Guide:</i> Required if the customer is responsible for 100% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay.  <i>Payer Requirement: (Same as Imp Guide).</i>
572-4U	AMOUNT OF COINSURANCE		RW	<i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes coinsurance as patient financial responsibility.  <i>Payer Requirement: (Same as Imp Guide).</i>
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	RW	<i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used.  <i>Payer Requirement: (Same as Imp Guide).</i>
393-MV	BENEFIT STAGE QUALIFIER		RW	<i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used.  <i>Payer Requirement: (Same as Imp Guide).</i>

	Response Pricing Segment Segment Identification (111-AM) = “23”			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
394-MW	BENEFIT STAGE AMOUNT		RW	<p><i>Imp Guide:</i> Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement: (Same as Imp Guide).</i></p>
577-G3	ESTIMATED GENERIC SAVINGS		RW	<p><i>Imp Guide:</i> This information should be provided when a patient selected the brand drug and a generic form of the drug was available. It will contain an estimate of the difference between the cost of the brand drug and the generic drug, when the brand drug is more expensive than the generic.</p> <p><i>Payer Requirement: (Same as Imp Guide).</i></p>
128-UC	SPENDING ACCOUNT AMOUNT REMAINING		RW	<p><i>Imp Guide:</i> This dollar amount will be provided, if known, to the receiver when the transaction had spending account dollars reported as part of the patient pay amount.</p> <p><i>Payer Requirement: (Same as Imp Guide).</i></p>
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT		RW	<p><i>Imp Guide:</i> Required when the patient meets the plan-funded assistance criteria, to reduce Patient Pay Amount (505-F5). The resulting Patient Pay Amount (505-F5) must be greater than or equal to zero.</p> <p><i>Payer Requirement: (Same as Imp Guide).</i></p>
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION		RW	<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another</p> <p><i>Payer Requirement: (Same as Imp Guide).</i></p>
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG		RW	<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient’s selection of a Brand drug.</p> <p><i>Payer Requirement: (Same as Imp Guide).</i></p>
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION		RW	<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient’s selection of a non-preferred formulary product.</p> <p><i>Payer Requirement: (Same as Imp Guide).</i></p>
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION		RW	<p><i>Imp Guide:</i> Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient’s selection of a Brand non-preferred formulary product.</p> <p><i>Payer Requirement: (Same as Imp Guide).</i></p>
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP		RW	<p><i>Imp Guide:</i> Required when the patient’s financial responsibility is due to the coverage gap.</p> <p><i>Payer Requirement: (Same as Imp Guide).</i></p>

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	Used when needed to relay DUR information to the pharmacy.

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

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	Used if COB or Other Payment Information is to be sent.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		RW	Imp Guide: Required if Other Payer ID (340-7C) is used.  Payer Requirement: (Same as Imp Guide).
340-7C	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).
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: (Same as Imp Guide).
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: (Same as Imp Guide).

Claim Billing/Claim Rebill Accepted/Rejected Response

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

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

	Response Transaction Header Segment			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	

	Response Transaction Header Segment			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Used if insurance information is needed.

	Response Insurance Segment Segment Identification (111-AM) = "25"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
545-2F	NETWORK REIMBURSEMENT ID		RW	<p><i>Imp Guide:</i> Required if needed to identify the network for the covered member.</p> <p>Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available.</p> <p>Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>

Response Patient Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Used if Patient information is to be returned.

	Response Patient Segment Segment Identification (111-AM) = "29"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	PATIENT FIRST NAME		RW	<p><i>Imp Guide:</i> Required if known.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
311-CB	PATIENT LAST NAME		RW	<p><i>Imp Guide:</i> Required if known.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
304-C4	DATE OF BIRTH		RW	<p><i>Imp Guide:</i> Required if known.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>

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

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		RW	<p><i>Imp Guide:</i> Required if needed to identify the transaction.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
510-FA	REJECT COUNT	Maximum count of 5.	R	



	Response Status Segment Segment Identification (111-AM) = “21”			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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.  Payer Requirement: (Same as Imp Guide).
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Imp Guide: Required if Additional Message Information (526-FQ) is used.  Payer Requirement: (Same as Imp Guide). Note: Current NCPDP and SS&C Health count supported = maximum of 9.
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: (Same as Imp Guide).
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY			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			Imp Guide: Required if Help Desk Phone Number (550-8F) is used.  Payer Requirement: (Same as Imp Guide).
550-8F	HELP DESK PHONE NUMBER			Imp Guide: Required if needed to provide a support telephone number to the receiver.  Payer Requirement (Same as Imp Guide). Note: Help Desk Phone Number may continue to be returned in 526-FQ Additional Message Information field.

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

	Response Claim Segment Segment Identification (111-AM) = “22”			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	Imp Guide: For Transaction Code of “B1”, in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (RxBilling).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Used if DUR information is needed to be returned.

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

Response Prior Authorization Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	Used if Prior Authorization is needed to be returned.

	Response Prior Authorization Segment Segment Identification (111-AM) = “26”			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

	Response Prior Authorization Segment Segment Identification (111-AM) = “26”			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
498-PY	PRIOR AUTHORIZATION NUMBER–ASSIGNED		RW	<p><i>Imp Guide:</i> Required when the receiver must submit this Prior Authorization Number in order to receive payment for the claim.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide). Note: Prior Authorization Number may continue to be returned in 526-FQ Additional Message Information field.</p>

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Used if COB or Other Payer information is needed to be returned.

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = “28”			Claim Billing/Claim Rebill 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		RW	<p><i>Imp Guide:</i> Required if Other Payer ID (340-7C) is used.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
340-7C	OTHER PAYER ID		RW	<p><i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		RW	<p><i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
356-NU	OTHER PAYER CARDHOLDER ID		RW	<p><i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
992-MJ	OTHER PAYER GROUP ID		RW	<p><i>Imp Guide:</i> Required if other insurance information is available for coordination of benefits.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
142-UV	OTHER PAYER PERSON CODE		RW	<p><i>Imp Guide:</i> Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		RW	<p><i>Imp Guide:</i> Required if needed to provide a support telephone number of the other payer to the receiver.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		RW	<p><i>Imp Guide:</i> Required when other coverage is known which is after the Date of Service submitted.</p> <p><i>Payer Requirement:</i> (Same as Imp Guide).</p>

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = “28”			Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
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: (Same as Imp Guide).

Claim Billing/Claim Rebill Rejected/Rejected Response

**CLAIM BILLING/CLAIM REBILL REJECTED/REJECTED RESPONSE**

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

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

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Used If additional messaging is needed.

	Response Message Segment Segment Identification (111-AM) = “20”			Claim Billing/Claim Rebill Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	MESSAGE		RW	Imp Guide: Required if text is needed for clarification or detail.  Payer Requirement: (Same as Imp Guide).

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

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

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement</i> (Same as Imp Guide).
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> (Same as Imp Guide).
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.  <i>Payer Requirement:</i> (Same as Imp Guide).
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used.  <i>Payer Requirement:</i> (Same as Imp Guide).
550-8F	HELP DESK PHONE NUMBER		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.  <i>Payer Requirement</i> (Same as Imp Guide). Note: Help Desk Phone Number may continue to be returned in 526-FQ Additional Message Information field.

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

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