

# ILLINOIS MEDICAID NCPDP VERSION D.Ø PAYOR SHEET

## MANAGED CARE ORGANIZATION (MCO) CLAIM BILLING/CLAIM REBILL

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

### GENERAL INFORMATION

Payer Name: <b>Illinois Medicaid Enterprise</b>		Date: <b>March 14, 2017</b>
Plan Name/Group Name: <b>Illinois Medicaid</b>	BIN: <b>Ø178Ø4</b>	PCN: <b>ILPOP</b>
Processor: <b>Change Healthcare (CHC)</b>		
Effective as of: <b>March 27, 2017</b>		NCPDP Telecommunication Standard Version/Release #: <b>D.Ø</b>
NCPDP Data Dictionary Version Date: <b>July 2007</b>		NCPDP External Code List Version Date: <b>July 2013</b>
Contact/Information Source: <b>1-217-524-2503</b>		
Certification Testing Window:		
Certification Contact Information: <b>1-877-782-5565</b>		
Provider Relations Help Desk Info: <b>1-877-782-5565</b>		
Other versions supported:		

### OTHER TRANSACTIONS SUPPORTED

Transaction Code	Transaction Name
B2	Claim Reversal

### FIELD LEGEND FOR COLUMNS

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

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

### MCO CLAIM BILLING/CLAIM REBILL TRANSACTION

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

Transaction Header Segment Questions	Check	MCO 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 (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

Field #	Transaction Header Segment <i>NCPDP Field Name</i>	Value	Payer Usage	MCO Claim Billing/Claim Rebill <i>Payer Situation</i>
1Ø1-A1	BIN NUMBER	<b>Ø178Ø4</b>	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	B1 – Claim billing B3 – Claim rebill
1Ø4-A4	PROCESSOR CONTROL NUMBER	ILPOP	M	

Transaction Header Segment				MCO Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
109-A9	TRANSACTION COUNT	1	M	1=One Occurrence
202-B2	SERVICE PROVIDER ID QUALIFIER	01=National Provider Identifier (NPI)	M	Only the National Provider ID (NPI) is supported
201-B1	SERVICE PROVIDER ID	.	M	NPI of the submitting pharmacy
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	No other values required

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

Insurance Segment Identification (111-AM) = "04"				MCO Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	Member ID as issued to the Medicaid beneficiary 9 byte numeric HFS recipient number for all transactions.

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

Patient Segment Identification (111-AM) = "01"				MCO Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
304-C4	DATE OF BIRTH		R	
305-C5	PATIENT GENDER CODE		R	
310-CA	PATIENT FIRST NAME		RW	Imp Guide: Required when the patient has a first name.
311-CB	PATIENT LAST NAME		R	

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

	Claim Segment Segment Identification (111-AM) = "Ø7"			MCO Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	<i>Imp Guide:</i> For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	ØØ=Compound Ø1=UPC Ø2=HRI Ø3=NDC	M	Use ØØ only when submitting claims for compounded prescription claims, in all other instances use the qualifier appropriate for the product ID in field 4Ø7-D7.
4Ø7-D7	PRODUCT/SERVICE ID		M	Use 'Ø' or 'ØØØØØØØØØØØØ' only when submitting claims for compounded prescription claims, in all other instances use the ID of the product being dispensed.
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER		RW	<i>Imp Guide:</i> Required if needed to associate multiple prescriptions/ services from the same sender to allow billing of the current prescription/service.
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE		RW	<i>Imp Guide:</i> Required if Associated Prescription/Service Reference Number (456-EN) is used.  Required if needed to associate multiple prescriptions/ services from the same sender to allow billing of the current prescription/service.
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER	Ø=Original Dispensing 1 to 99=Refill Number	R	Must be Ø for original dispensing of Schedule II drugs; patients of nursing homes are exempt.
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	1=Not a Compound 2=Compound	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	Date written must be within 6 months of Date of Service for controlled drugs, 1 year (366 days) for non-controlled drugs.
415-DF	NUMBER OF REFILLS AUTHORIZED	Ø=No Refills Authorized 1 through 99, with 99 being as needed, refills unlimited	RW	<i>Imp Guide:</i> Required if necessary for plan benefit administration.  <i>Payer Requirement:</i> Required when available on first fill.
419-DJ	PRESCRIPTION ORIGIN CODE		R	<i>Imp Guide:</i> Required if necessary for plan benefit administration.  <i>Payer Requirement:</i> Required when known.
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum Count of 3	RW	<i>Imp Guide:</i> Required if Submission Clarification Code (42Ø-DK) is used.  <i>Payer Requirement:</i> Same as Imp. Guide

	Claim Segment Segment Identification (111-AM) = "Ø7"			MCO Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
42Ø-DK	SUBMISSION CLARIFICATION CODE	Ø8=Process Compound for Approved Ingredients 2Ø= 34ØB	RW	<p><i>Imp Guide:</i> Required if clarification is needed and value submitted is greater than zero (Ø).</p> <p><i>Payer Requirement:</i> Required when provider will accept payment on one or more, but not necessarily all, ingredients of a multi-ingredient compound and consider payment received as payment in full for the prescribed products.</p> <p>Use indicator (2Ø=34ØB) for 34ØB claims.</p>
3Ø8-C8	OTHER COVERAGE CODE	Ø=Not specified 1=No other coverage 2=Other Coverage Exists- payment collected 3=Other coverage billed – claim not covered 8=Claim is billing for patient financial responsibility only	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> Accepting 'Ø' when Other Coverage is not specified. Claims should be defaulted to this value if no other value is provided.</p> <p>Accepting 1 to override prior claim rejection caused by other insurance being applicable as primary insurer in <b>State</b> Medicaid eligibility data, but other insurance is not in effect. <b>This value should not be the default value.</b></p> <p>Accepting 2 for reporting TPL payment information.</p> <p>Accepting 3 for Part D excluded drugs</p> <p>If a '3' is submitted, there should be a minimum of 1 Other Payer Reject Code (472-6E) submitted and no Other Payer-Patient Responsibility Qualifier field (351-NP) submitted.</p> <p>If 8 is submitted, Other Payer-Patient Resp. Amount (352-NQ) with applicable qualifiers must be submitted.</p>

Claim Segment Segment Identification (111-AM) = "07"				MCO Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
461-EU	PRIOR AUTHORIZATION TYPE CODE	Ø=Not Specified 1=Prior Auth 2=Med Cert	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> '1'=Prior Auth requires a valid PA Number; '2' =Med Cert and requires a clarifying State defined value in PA Number Submitted (462-EV)
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Submit PA Number for the Med Cert and Payer Defined situations identified in 461-EU  72 = 72 hour Emergency Supply	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.  <i>Payer Requirement:</i> Submit the value provided by IL staff when needed to override standard rules of coverage, pricing and/or patient financial responsibility.
343-HD	DISPENSING STATUS		RW	Used only in situations where inventory shortages do not allow the full quantity to be dispensed.
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	<i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription.
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	<i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription.
357-NV	DELAY REASON CODE		RW	<i>Imp Guide:</i> Required when needed to specify the reason that submission of the transaction has been delayed.
995-E2	ROUTE OF ADMINISTRATION		RW	<i>Imp Guide:</i> Required if specified in trading partner agreement.  <i>Payer Requirement:</i> Same as Imp Guide

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

Pricing Segment Segment Identification (111-AM) = "11"				MCO Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	INGREDIENT COST SUBMITTED		R	34ØB pharmacies – submit 34ØB cost here with the Basis of Cost Determination (423-DN) indicator of 'Ø8'.
43Ø-DU	GROSS AMOUNT DUE		R	
412-DC	DISPENSING FEE SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.  <i>Payer Requirement:</i> Same as Imp Guide.

Pricing Segment Segment Identification (111-AM) = "11"				MCO Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.  <i>Payer Requirement:</i> Same as Imp Guide.
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:</i> Same as Imp Guide.
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	Ø4-Administrative Cost	R	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted (48Ø-H9) is used.  <i>Payer Requirement:</i> This segment must contain the Ø4 value in order for the MCO payment amount to be supplied in 48Ø-H9.
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED	MCO payment amount	R	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.  <i>Payer Requirement:</i> This segment must contain the MCO payment amount.
426-DQ	USUAL AND CUSTOMARY CHARGE		R	<i>Imp Guide:</i> Required if needed per trading partner agreement.  <i>Payer Requirement:</i> <b>State</b> Medicaid agreements require submission of Usual and Customary Charge. Not used in 34ØB claims.
423-DN	BASIS OF COST DETERMINATION		RW	<i>Payer Requirement:</i> Use indicator (Ø8=34ØB) for 34ØB claims, with the amount being submitted in the Ingredient Cost Submitted (4Ø9-D9) field.

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

Prescriber Segment Segment Identification (111-AM) = "Ø3"				MCO Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	Ø1=National Provider Identifier (NPI)	R	<i>Imp Guide:</i> Required if Prescriber ID (411-DB) is used.  <i>Payer Requirement:</i> Field should always be sent

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			MCO Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
411-DB	PRESCRIBER ID	National Provider ID	R	<p><i>Imp Guide:</i> Required if this field could result in different coverage or patient financial responsibility.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> NPI of prescriber is required.</p>
427-DR	PRESCRIBER LAST NAME		R	<p><i>Imp Guide:</i> Required when the Prescriber ID (411-DB) is not known.</p> <p>Required if needed for Prescriber ID (411-DB) validation/clarification.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
498-PM	PRESCRIBER PHONE NUMBER		RW	<p><i>Imp Guide:</i> Required if needed for Workers' Compensation.</p> <p>Required if needed to assist in identifying the prescriber.</p> <p>Required if needed for Prior Authorization process.</p> <p><i>Payer Requirement:</i> Same as Imp Guide.</p>
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	01-NPI	RW	<p><i>Imp Guide:</i> Required if Primary Care Provider ID (421-DL) is used.</p>
421-DL	PRIMARY CARE PROVIDER ID		RW	<p><i>Imp Guide:</i> Required if needed for receiver service billing determination, if known and available.</p> <p>Required if this field could result in different coverage or patient financial responsibility.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p>
470-4E	PRIMARY CARE PROVIDER LAST NAME		RW	<p><i>Imp Guide:</i> Required if this field is used as an alternative for Primary Care Provider ID (421-DL) when ID is not known.</p> <p>Required if needed for Primary Care Provider ID (421-DL) validation/clarification.</p>
364-2J	PRESCRIBER FIRST NAME		RW	<p><i>Imp Guide:</i> Required if needed to assist in identifying the prescriber.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p>

Coordination of Benefits/Other Payments Segment Questions	Check	MCO If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc claims.

	Coordination of Benefits/Other Payments Segment Identification (111-AM) = "Ø5"			MCO Claim Billing/Claim Rebill Scenario 1 – Other Payer Amount Paid Repetitions Only
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		RW	<i>Imp Guide:</i> Required if Other Payer ID (34Ø-7C) is used.  <i>Payer Requirement:</i> Submit qualifier appropriate to the value submitted in Other Payer ID (34Ø-7C).
34Ø-7C	OTHER PAYER ID		RW	<i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication.  <i>Payer Requirement:</i> Submit National Payer ID (also referenced as "HPID") of the <b>primary</b> payer when available, otherwise the BIN used for claim submission to the other payer is required.
443-E8	OTHER PAYER DATE		RW	<i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.  <i>Payer Requirement:</i> Payment or denial date of the claim submitted to the other payer.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used.  <i>Payer Requirement:</i> Required when Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Only Ø7= Drug Benefit	RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used.  <i>Payer Requirement:</i> Required when Other Payer Amount Paid (431-DV) is used.
431-DV	OTHER PAYER AMOUNT PAID		RW	<i>Payer Requirement:</i> Required if other payer has returned a paid response. If OCC=2 (308-C8), value > Ø .
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used.  <i>Payer Requirement:</i> Same as Imp Guide.



Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"			MCO Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
472-6E	OTHER PAYER REJECT CODE		RW	<p><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).</p> <p><i>Payer Requirement:</i> Submit as many reject codes as were returned by the other payer, up to the maximum identified in Other Payer Reject Count (471-5E).</p>

DUR/PPS Segment Questions	Check	MCO If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required if DUR information needs to be sent

DUR/PPS Segment Segment Identification (111-AM) = "08"			MCO Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	<p><i>Imp Guide:</i> Required if DUR/PPS Segment is used.</p> <p><i>Payer Requirement:</i> Same as Imp. Guide</p>
439-E4	REASON FOR SERVICE CODE		RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.</p> <p>Required if this field affects payment for or documentation of professional pharmacy service.</p> <p><i>Payer Requirement:</i> Same as Imp. Guide</p>
440-E5	PROFESSIONAL SERVICE CODE	MA= Vaccine	RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.</p> <p>Required if this field affects payment for or documentation of professional pharmacy service.</p> <p><i>Payer Requirement:</i> Same as Imp. Guide</p>

	<b>DUR/PPS Segment Segment Identification (111-AM) = “Ø8”</b>			<b>MCO Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
441-E6	RESULT OF SERVICE CODE		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement:</i> Same as Imp. Guide
474-8E	DUR/PPS LEVEL OF EFFORT		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this field affects payment for or documentation of professional pharmacy service.  <i>Payer Requirement:</i> Same as Imp. Guide

<b>Compound Segment Questions</b>	<b>Check</b>	<b>MCO If Situational, Payer Situation</b>
This Segment is always sent		
This Segment is situational	X	Required when the pharmacy is dispensing a compound of multiple ingredients and requesting payment for the prescribed compound from <b>State Medicaid</b> .

	<b>Compound Segment Segment Identification (111-AM) = “1Ø”</b>			<b>MCO Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	01=UPC 02=HRI Ø3=NDC	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		RW	<i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed.  <i>Payer Requirement:</i> Required when the pharmacy is seeking compensation for the individual ingredient.

Compound Segment Segment Identification (111-AM) = "10"				MCO Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	08= 340B	RW	<i>Payer Requirement:</i> Required when a value is submitted in Compound Ingredient Drug Cost (449-EE).

Narrative Segment Questions	Check	MCO If Situational, Payer Situation
This Segment is always sent	X	Required on paid claims
This Segment is situational		

Narrative Segment Segment Identification (111-AM) = "16"				MCO
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
390-BM	NARRATIVE MESSAGE	YYYYMMDD*YYYYMMDD	R	<i>Payer Requirement:</i> This segment must contain the MCO Claim Received Date and the MCO Claim Paid Date.

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

# RESPONSE MCO CLAIM BILLING/CLAIM REBILL PAYER SHEET

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

\*\* Start of Response MCO Payer Sheet \*\*

### GENERAL INFORMATION

Payer Name: <b>Illinois Medicaid Enterprise</b>	Date: <b>March 14, 2017</b>	
Plan Name/Group Name: <b>Illinois Medicaid</b>	BIN: <b>017804</b>	PCN: <b>ILPOP</b>

### MCO RESPONSE

The following lists the segments and fields in a MCO response Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

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

	Response Transaction Header Segment			MCO-Accepted/Approved
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 Message Header Segment Questions	Check	MCO 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	<i>Returned when needed for transmission-level messaging.</i>

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

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

	Response Status Segment Segment Identification (111-AM) = "21"			MCO – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	P = Paid D = Duplicate	M	

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>MCO – Accepted/Approved</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
503-F3	AUTHORIZATION NUMBER		R	
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide: Required if Additional Message Information (526-FQ) is used.</i>  <i>Payer Requirement: Same as Imp Guide</i>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide: Required if Additional Message Information (526-FQ) is used.</i>  <i>Payer Requirement: Same as Imp Guide</i>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide: Required when additional text is needed for clarification or detail.</i> Note: For the timely filing edit– "System Date – DOS" will be displayed.  <i>Payer Requirement: Same as Imp Guide</i>
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>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.</i>  <i>Payer Requirement: Same as Imp Guide</i>
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03=Processor/PBM	RW	<i>Imp Guide: Required if Help Desk Phone Number (550-8F) is used.</i>  <i>Payer Requirement: Will be returned</i>
550-8F	HELP DESK PHONE NUMBER	217-524-2503/ 877-782-5565	RW	<i>Imp Guide: Required if needed to provide a support telephone number to the receiver.</i>  <i>Payer Requirement: Same as Imp Guide</i>

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

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

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

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>MCO – Accepted/Approved</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
505-F5	PATIENT PAY AMOUNT		R	Reflects the Medicaid Copay amount
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.  <i>Payer Requirement:</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
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	<i>Imp Guide:</i> Required if this value is used to arrive at the final reimbursement.  Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.  <i>Payer Requirement:</i> Same as Imp Guide
509-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		RW	<i>Imp Guide:</i> Required if Ingredient Cost Paid (506-F6) is greater than zero (Ø).  <i>Payer Requirement:</i> Required if Basis of Cost Determination (423-DN) is submitted on billing. (Required for 340B drugs).

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>MCO – Accepted/Approved</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</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:</i> Same as Imp Guide
346-HH	BASIS OF CALCULATION DISPENSING FEE		RW	<i>Imp Guide:</i> Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill).
347-HJ	BASIS OF CALCULATION COPAY		RW	<i>Imp Guide:</i> Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill).

## MCO ACCEPTED/REJECTED RESPONSE

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

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

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

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

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

	Response Status Segment Segment Identification (111-AM) = "21"	Value	Payer Usage	MCO-Accepted/Rejected <i>Payer Situation</i>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER		R	
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence.  <i>Payer Requirement:</i> Same as Imp Guide



	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>MCO-Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp Guide
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.  <i>Payer Requirement:</i> Same as Imp Guide
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3=Processor/PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used.  <i>Payer Requirement:</i> Will be returned
55Ø-8F	HELP DESK PHONE NUMBER	217-524-2503/ 877-782-5565	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
987-MA	URL	<a href="http://www.HFS.illinois.gov/pharmacy">www.HFS.illinois.gov/pharmacy</a>	R	<i>Imp Guide:</i> Required for informational purposes only to relay health care communications via the Internet.

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

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

## MCO REJECTED/REJECTED RESPONSE

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

	Response Transaction Header Segment			MCO- Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	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 Header Segment Questions	Check	MCO- Rejected/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<i>Returned when needed for transmission-level messaging.</i>

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

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

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

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>MCO- Rejected/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used.  <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.  <i>Payer Requirement:</i> Same as Imp Guide
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3=Processor/ PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used.  <i>Payer Requirement:</i> Will be returned
55Ø-8F	HELP DESK PHONE NUMBER	217-524-2503/877-782-5565	RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.  <i>Payer Requirement:</i> Will be returned
987-MA	URL	<a href="http://www.HFS.illinois.gov/pharmacy">www.HFS.illinois.gov/pharmacy</a>	R	<i>Imp Guide:</i> Required for informational purposes only to relay health care communications via the Internet.

**\*\* End of Response MCO Payer Sheet \*\***

# ILLINOIS MEDICAID NCPDP VERSION D.Ø CLAIM REVERSAL MANAGED CARE ORGANIZATION (MCO) REQUEST CLAIM REVERSAL

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

## GENERAL INFORMATION

Payer Name: <b>Illinois Medicaid Enterprise</b>	Date: <b>March 14, 2017</b>
Plan Name/Group Name: <b>Illinois Medicaid</b>	BIN: <b>Ø178Ø4</b> <span style="float: right;">PCN: <b>ILPOP</b></span>

## 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

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	<b>State</b> Medicaid will accept reversal/ resubmission within a 2 year time period from date of service on the claim

## CLAIM REVERSAL TRANSACTION

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

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

Field #	Transaction Header Segment <i>NCPDP Field Name</i>	Value	Payer Usage	Claim Reversal <i>Payer Situation</i>
1Ø1-A1	BIN NUMBER	<b>Ø178Ø4</b>	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	Claim Reversal
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	1	M	1=One Occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1=National Provider Identifier (NPI)	M	Only the National Provider ID (NPI) is supported
2Ø1-B1	SERVICE PROVIDER ID		M	NPI of the submitting pharmacy
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	No other values required

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

Insurance Segment Segment Identification (111-AM) = "04"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID		M	Member ID as issued to the Medicaid beneficiary 9 byte numeric HFS recipient number for all transactions.

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

Claim Segment Segment Identification (111-AM) = "07"			Claim Reversal	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	01 = Rx Billing	M	Imp Guide: For Transaction Code of "B2", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	00=Compound 01=UPC 02=HRI 03=NDC	M	Use 00 only when submitting claims for compounded prescription claims, in all other instances use the qualifier appropriate for the product ID in field 407-D7
407-D7	PRODUCT/SERVICE ID		M	Use '0' only when submitting claims for compounded prescriptions, in all other instances use the ID of the product being dispensed

**\*\* End of Request MCO Reversal (B2) Payer Sheet \*\***

# RESPONSE CLAIM REVERSAL PAYER SHEET

## MCO REVERSAL ACCEPTED/APPROVED RESPONSE

\*\* Start of MCO Reversal Response (B2) Payer Sheet \*\*

### GENERAL INFORMATION

Payer Name: <b>Illinois Medicaid Enterprises</b>	Date: <b>March 14, 2017</b>	
Plan Name/Group Name: <b>Illinois Medicaid</b>	BIN: <b>017804</b>	PCN: <b>ILPOP</b>

### CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

The following lists the segments and fields in a Claim Reversal response (Approved) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

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

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

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

	Response Message Segment Segment Identification (111-AM) = "20"	Value	Payer Usage	Claim Reversal – Accepted/Approved Payer Situation
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	MESSAGE		RW	<i>Imp Guide: Required if text is needed for clarification or detail.</i>  <i>Payer Requirement: Same as Imp Guide</i>

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

	Response Status Segment Segment Identification (111-AM) = "21"	Value	Payer Usage	Claim Reversal – Accepted/Approved Payer Situation
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	A = Approved	M	
503-F3	AUTHORIZATION NUMBER		RW	<i>Imp Guide: Required if needed to identify the transaction.</i>  <i>Payer Requirement: Same as Imp. Guide</i>
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	<i>Imp Guide: Required if Additional Message Information (526-FQ) is used.</i>  <i>Payer Requirement: Same as Imp Guide</i>

Response Status Segment Segment Identification (111-AM) = "21"				Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	<i>Imp Guide: Required if Additional Message Information (526-FQ) is used.</i>  <i>Payer Requirement: Same as Imp Guide</i>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide: Required when additional text is needed for clarification or detail.</i>  <i>Payer Requirement: Same as Imp Guide</i>
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>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.</i>  <i>Payer Requirement: Same as Imp Guide</i>
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3=Processor/PBM	RW	<i>Imp Guide: Required if Help Desk Phone Number (55Ø-8F) is used.</i>  <i>Payer Requirement: Will be returned</i>
55Ø-8F	HELP DESK PHONE NUMBER	217-524-2503/877-782-5565	RW	<i>Imp Guide: Required if needed to provide a support telephone number to the receiver.</i>  <i>Payer Requirement: Same as Imp Guide</i>

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

Response Claim Segment Segment Identification (111-AM) = "22"				Claim Reversal – Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	<i>Imp Guide: For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).</i>
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

### MCO REVERSAL ACCEPTED/REJECTED RESPONSE

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



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

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

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

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

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

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Reversal – Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.  <i>Payer Requirement:</i> Same as Imp Guide
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3=Processor/ PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used.  <i>Payer Requirement:</i> Same as Imp Guide
55Ø-8F	HELP DESK PHONE NUMBER	217-524-2503/877-782-5565	RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.  <i>Payer Requirement:</i> Same as Imp Guide

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

	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Reversal – Accepted/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	<i>Imp Guide:</i> For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

## MCO REVERSAL REJECTED/REJECTED RESPONSE

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

	Response Transaction Header Segment			Claim Reversal – Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B2	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	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 Reversal – Rejected/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	Returned when needed for transmission-level messaging

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

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

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

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Reversal – Rejected/Rejected</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail.  <i>Payer Requirement:</i> Same as Imp Guide
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.  <i>Payer Requirement:</i> Same as Imp Guide
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3=Processor/ PBM	RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used.  <i>Payer Requirement:</i> Will be returned
55Ø-8F	HELP DESK PHONE NUMBER	217-524-2503/877-782-5565	RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver.  <i>Payer Requirement:</i> Will be returned

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