Addendum 13

PRMMIS_PHASE_I_837D_Companion_Guide_v 7.0

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GOVERNMENT OF PUERTO RICO
Department of Health
Medicaid Program

Puerto Rico Medicaid Management Information System Fiscal Agent Services

PRMMIS_NCPDP_Post_Adjudication_Companion_Guide

Puerto Rico Medicaid Program Post Adjudication Companion Guide

HIPAA Transaction Standard Companion Guide

Refers to the NCPDP Post Adjudication Standard V4.2

Companion Guide

Version 4.Ø – November 2Ø2Ø

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Disclosure Statement

This template is based on the CORE v5Ø1Ø Master Companion Guide Template and adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2ØØ3.

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Preface

This Companion Guide to the NCPDP Post Adjudication 4.2 Implementation Guide clarifies and specifies the data content when exchanging electronically with Puerto Rico Medicaid Program. Transmissions based on this Companion Guide, used in tandem with the Post Adjudication 4.2 Implementation Guides, are compliant with NCPDP. This Companion Guide is intended to convey information that is within the framework of the Post Adjudication 4.2 Implementation Guides. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

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1 Introduction

NCPDP – NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and Issuers. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The National Council for Prescription Drug Programs (NCPDP) is a non-profit organization formed in 1976. It is dedicated to the development and dissemination of voluntary consensus standards that are necessary to transfer information that is used to administer the prescription drug benefit program.

Refer to the NCPDP Post Adjudication Version 4.2 documents (NCPDP Post Adjudication Standard Implementation Guide (IG), Data Dictionary, and External Code List) for more detailed information on field values and segments.

The following information is intended to serve only as a Companion Guide to the aforementioned NCPDP Post Adjudication Standard Version 4.2 documents. The use of this Companion Guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This Companion Guide supplements, but does not contradict, any requirements in the NCPDP Post Adjudication Standard Version 4.2 Implementation Guide and related documents.

To request a copy of the NCPDP Standard Formats or for more information contact the National Council for Prescription Drug Programs, Inc. at www.ncpdp.org. The contact information is as follows:

National Council for Prescription Drug Programs
9240 East Raintree Drive Scottsdale, AZ 85260
Phone: (480) 477-1000
Fax (480) 767-1042

This section describes how the NCPDP Post Adjudication (4.2) Implementation Guides (IGs) will be **detailed** with the use of a table. The table contains a row for each element/field of the NCPDP Post Adjudication V4.2 records.

Each row will indicate whether the element/field is required or is not required by PRMMIS.

The following table is an example:

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Table 1 – Example NCPDP Post Adjudication 4.2 Implementation Guides Table

SHADED Rows represent "sections" in the NCPDP Post Adjudication Implementation Guide
NON-SHADED Rows represent "data elements" in the NCPDP Post Adjudication Implementation Guide.

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	PA – Post Adjudication History Header Record	M	P	A	2	1	2	Required
6Ø1-Ø9	TOTAL RECORD COUNT	Total number of records being submitted, including header and trailer		M	P	N	1Ø	3	12	Required
895	TOTAL NET AMOUNT DUE	Summarization of Net Amount Due (281).		M	P	D	12	13	24	Required

1.1 Scope

This Companion Guide is to be used in addition to the NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code List.

This Companion Guide contains supplemental information for creating transactions for PRMP while ensuring compliance with the associated Post Adjudication 4.2 Implementation Guide.

The Transaction Instruction component of this Companion Guide must be used in conjunction with an associated NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code List.

The instructions in this Companion Guide are not intended to be stand-alone requirements documents. This Companion Guide conforms to all the requirements of any associated NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code List, and is in conformance with NCPDP's Fair Use and Copyright statements.

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2 NCPDP Post Adjudication Transaction Standard Version 4.2 File Information

The batch specifications contained in this document include the header, detail, compound and trailer segments. Batch files should contain one header record, one trailer record, and a maximum of 200,000 transaction details.

- Post Adjudication History Header (Occurs 1)
- Post Adjudication History Detail (Occurs 1 to 200,000)
- Post Adjudication History Compound Detail 1 (Occurs 1 as Applicable with Detail Record)
- Post Adjudication History Compound Detail 2 (Occurs 1 as Applicable with Detail Record)
- Post Adjudication History Trailer (Occurs 1)

Note: All ingredients in a Compound detail should be consecutive and contiguous to each other; gaps or holes in the sequence are not accepted. Also, only send a Compound Detail 2 record if and only if Compound Detail 1 has all 8 ingredients already set up, and more ingredients or components are required.

Batch files should have a creation date in the batch header that is valid and less than 30 days old from the submission date of the file, or the file will be rejected. Values in the header and trailer will be edited to verify that they contain appropriate values.

2.1 Record Delimiter

The V4.2 Post Adjudication V4.2 record is 3,700 characters followed by a Carriage return only – UNIX-based system (record length n+1).

2.2 Over Punch Sign Requirements

Table 2 – Over Punch Sign Requirements

Positive Signed		Negative Signed	
Numeric	Graphic	Numeric	Graphic
0	{	0	}
1	A	1	J
2	B	2	K
3	C	3	L
4	D	4	M
5	E	5	N

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Positive Signed		Negative Signed	
Numeric	**Graphic**	**Numeric**	**Graphic**
6	F	6	O
7	G	7	P
8	H	8	Q
9	I	9	R

Examples:

1. 10{ is 100
2. 45A is 451

Decimal points are usually implied, not explicit in the text. Using numbers with two decimal digits: 10000{ is 100.00.

2.3 Additional NCPDP Post Adjudication Transaction Standard Version 4.2 File Information

The following definitions are given to ensure consistency of interpretation.

- **Field** – The Post Adjudication Transaction Standard Version 4.2 field number
- **Field Name** – The Post Adjudication Transaction Standard Version 4.2 field name
- **Description** – A short description of field
- **Values** – Required or default value(s) for each field
- **Usage** – Field designation – Indicates whether a field is mandatory, situational, or not used. Mandatory fields are made mandatory by the NCPCP Post Adjudication Transaction Standard Version 4.2 and/or required by the processor. If a field is situational and data does not exist for the field, the field MUST be populated with the appropriate padding (default value). If a field is not required, note that PRMMIS will not process any data submitted.
  - M – Mandatory field
  - S – Situational field
  - N/U – Not used (PRMMIS will not use information sent in this field)
- **Source** – Data source
  - C – Submitted Claim or the Processor's response to the Submitted Claim
  - P – Processor/Payer

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- **Format** – Field format values
  - A – Alpha Numeric – upper case when alpha, always left justified, space filled, printable characters and **default values of spaces**
    - Example: X(14) represents "1234ABC44bbbbb"
  - N – Unsigned Numeric – always right justified, zero filled and **default values of zeros**
    - Example: 9(7)v999 represents "9999999999"
  - D – Signed Numeric – sign is internal and trailing (see Section **Over Punch Sign Requirements**), zero always positive, always right justified, zero filled dollar-cents amount with 2 positions to the right of the implied decimal point, all other positions to the left of the implied decimal point and **default values of positive zeros**
    - Example: "D" fields of length 8 represent $$$$$$cc
- **Size** – The field length
- **Start** – The starting position of the field in the record
- **End** – The ending position of the field in the record
- **PRMP Comment** – Notes/comments about specific fields

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3 Naming Convention Rules for NCPDP V4.2 Post Adjudication File:

Position 1 – 4 = 4 byte abbreviation of PBM/MAO's name
Position 5 – 6 = sequence number of file (each file limited to 200,000 claims)
Position 7 = underscore
Position 8 – 20 = Always use PRM_ClaimData
Position 21 = underscore
Position 22 – 29 = Date file was created (YYYYMMDD format)
Position 30 – 33 = use .dat or .zip

Example #1:
Submission Date: 11/01/2019
Total Number of Claims: 300,000

ABRV01_ PRM_ClaimData_20191101.dat [First 200,000 claims]
ABRV02_ PRM_ClaimData_20191101.dat [Last 100,000 claims]

Example #2:
Submission Date: 11/15/2019
Total No of Claims: 500,000

ABRV01_ PRM_ClaimData_20191115.dat [First 200,000 claims]
ABRV02_ PRM_ClaimData_20191115.dat [Second 200,000 claims]
ABRV03_ PRM_ClaimData_20191115.dat [Last 100,000 claims]

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4 Transaction Specific Information

This section describes how the NCPDP Post Adjudication 4.2 Implementation Guide (IG), Data Dictionary, and the External Code List will be used. The tables contain a row for each data element that PRMP has something additional, over and above, the information in the IGs in addition to any other information tied directly to a data element pertinent to trading electronically with PRMP

4.1 POST ADJUDICATION HISTORY HEADER RECORD

Table 3 – Post Adjudication History Header Record

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	PA – Post Adjudication History Header Record	M	P	A	2	1	2	Required
1Ø2-A2	VERSION/ RELEASE NUMBER	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	42 – Version 4.2	M	P	A	2	3	4	Required
879	SENDING ENTITY IDENTIFIER	Party creating the data enclosed or the entity for whom the data is being enclosed.	PRMP assigned six-digit trading partner ID	M	P	A	24	5	28	Required
8Ø6-5C	BATCH NUMBER	This number is assigned by the processor/sender. A number generated by the sender to uniquely identify this batch from others, especially when multiple batches may be sent in one day.		M	P	N	7	29	35	Required
88Ø-K2	CREATION DATE	Date that the file was created. Not older than 3Ø days from the actual submission date.	Format CCYYMMDD	M	P	N	8	36	43	Required
88Ø-K3	CREATION TIME	Time that the file was created.	Format HHMM	M	P	N	4	44	47	Required

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
88Ø-K7	RECEIVER ID	An identification number of the endpoint receiver of the data file.	PRMMIS	M	P	A	24	48	71	Required
6Ø1-Ø6	REPORTING PERIOD START DATE	The first day of the period being reported in the file	Format CCYYMMDD	M	P	N	8	72	79	Required
8Ø1-Ø5	REPORTING PERIOD END DATE	The last day of the period being reported in the file	Format CCYYMMDD	M	P	N	8	8Ø	87	Required
7Ø2-MC	FILE TYPE	Code identifying whether the file contained test or production data.	T – Test – In processing systems, the test environment P – Production – In processing systems, the live environment	M	P	A	1	88	88	Required
981-JV	TRANSMISSION ACTION	Indicates whether this is a replacement file, file updates, or a file delete.	O – Original Submission (New) – a new file	M	P	A	1	89	89	Required
588	SUBMISSION NUMBER	Indicates the number of times that a data set has been resent.	Blank – Not Specified ØØ – First Submission Ø1 – First Resubmission Ø2 – Second Resubmission Ø3 – 99 – Number of Resubmission	M	P	A	2	9Ø	91	Required
	FILLER			N/U	P	A	36Ø9	92	37ØØ	

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4.2 POST ADJUDICATION HISTORY DETAIL RECORD

Table 4 – Post Adjudication History Detail Record

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted	DE – Post Adjudicaton History Detail Record	M	P	A	2	1	2	Required
398	RECORD INDICATOR	Action to be taken on the record.	Ø – New Record	S	P	A	1	3	3	Required
SECTION DENOTES ELIGIBILITY CATEGORY:										
248	ELIGIBLE COVERAGE CODE	Coverage Level Code. Code indicating the level of coverage being provided for the insured.	IND – Individual	S	P	A	3	4	6	Required
898	USER BENEFIT ID	Member's benefit ID based upon User Group Number from Eligibility when submitted by Client		N/U	P	A	1Ø	7	16	
899	USER COVERAGE ID	Member's coverage ID based upon User Group Number submitted by Client on eligibility data.		N/U	P	A	1Ø	17	26	
246	ELIGIBILITY GROUP ID	Identifier of the group that determines eligibility parameters for the member when submitted by the client		N/U	P	A	15	27	41	
27Ø	LINE OF BUSINESS CODE	Line of Business Code from Client eligibility or as defined by trading partner agreement		N/U	P	A	6	42	47	
267	INSURANCE CODE	Special group/member data as supplied on eligibility record when supplied by the client		N/U	P	A	2Ø	48	67	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
22Ø	CLIENT ASSIGNED LOCATION CODE	The location of the member within the Client's Company from Client eligibility when submitted by the client.		N/U	P	A	2Ø	68	87	
222	CLIENT PASS THROUGH	Information from Client eligibility when submitted by the client.		N/U	P	A	2ØØ	88	287	
SUBSECTION DENOTES CARDHOLDER INFORMATION:										
3Ø2-C2	CARDHOLDER ID	Insurance ID assigned to the cardholder or identification number used by the plan.		M	C/P	A	2Ø	288	3Ø7	Required PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number.
716-SY	LAST NAME	Last name.		S	P	A	35	3Ø8	342	Required when available in the payer's adjudication system
717-SX	FIRST NAME	First name.		S	P	A	35	343	377	Required when available in the payer's adjudication system
718	MIDDLE INITIAL	Middle initial		N/U	P	A	1	378	378	
28Ø	NAME SUFFIX	Individual name suffix.		N/U	P	A	1Ø	379	388	
726-SR	ADDRESS LINE 1	First line of address information.		N/U	P	A	4Ø	389	428	
727-SS	ADDRESS LINE 2	Second line of address information.		N/U	P	A	4Ø	429	468	
728	CITY	Free-form text for city name.		N/U	P	A	3Ø	469	498	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
729-TA	STATE/ PROVINCE ADDRESS	The State/Province Code of the address.		N/U	P	A	2	499	5ØØ	
73Ø	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.		N/U	P	A	15	5Ø1	515	
B36-1W	ENTITY COUNTRY CODE	Code of the country.		N/U	P	A	2	516	517	
214	CARDHOLDER DATE OF BIRTH	Date of Birth of Member.		N/U	P	N	8	518	525	
721-MD	GENDER CODE	Code identifying the gender of the individual.	Blank – Unknown or Unspecified 1 – Male 2 – Female	S	P	N	1	526	526	Required when available in the payer's adjudication system
274	MEDICARE PLAN CODE	This represents if the member is eligible for Medicare coverage as provided in eligibility data		N/U	P	A	1	527	527	
288	PAYROLL CLASS	A field defined by the client indicating the payroll class of the member.		N/U	P	A	1	528	528	
SECTION DENOTES PATIENT INFORMATION:										
331-CX	PATIENT ID QUALIFIER	Code qualifying the 'Patient ID' (332-CY).	Ø6 – Medicaid ID – A number assigned by a state Medicaid agency	S	P	A	2	529	53Ø	Required
332-CY	PATIENT ID	ID assigned to the patient.		S	P	A	2Ø	531	55Ø	Required PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number.

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
716-SY	LAST NAME	Last name.		N/U	P	A	35	551	585	
717-SX	FIRST NAME	First name.		N/U	P	A	35	586	62Ø	
718	MIDDLE INITIAL	Middle initial		N/U	P	A	1	621	621	
28Ø	NAME SUFFIX	Individual name suffix.		N/U	P	A	1Ø	622	631	
726-SR	ADDRESS LINE 1	First line of address information.		N/U	P	A	4Ø	632	671	
727-SS	ADDRESS LINE 2	Second line of address information.		N/U	P	A	4Ø	672	711	
728	CITY	Free-form text for city name.		N/U	P	A	3Ø	712	741	
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.		N/U	P	A	2	742	743	
73Ø	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.		N/U	P	A	15	744	758	
A43-1K	PATIENT COUNTRY CODE	Code of the country.		N/U	P	A	2	759	76Ø	
3Ø4-C4	DATE OF BIRTH	Date of Birth of Member.	Default ØØØØØØØØ	S	P	N	8	761	768	Required when available in the payer's adjudication system
3Ø5-C5	PATIENT GENDER CODE	Code identifying the gender of the patient.	Default Ø	N/U	P	N	1	769	769	
247	ELIGIBILITY/PATIENT RELATIONSHIP CODE	Individual Relationship Code. Code indicating the relationship between two individuals or entities.	ØØ – Not Applicable	N/U	P	N	2	77Ø	771	
2Ø8	AGE	Calculated from Date of Birth (3Ø4-C4)	Default ØØØ	N/U	P	N	3	772	774	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
3Ø3-C3	PERSON CODE	Code assigned to a specific person within a family		N/U	P	A	3	775	777	
3Ø6-C8	PATIENT RELATIONSHIP CODE	Code indicating relationship of patient to cardholder.	Ø – Not Specified	N/U	C	N	1	778	778	
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE	Code indicating that the pharmacy is clarifying eligibility for a patient.		N/U	C	A	1	779	779	
336-8C	FACILITY ID	ID assigned to the patient's clinic/host party.		N/U	P	A	1Ø	78Ø	789	
SECTION DENOTES BENEFIT CATEGORY:										
3Ø1-C1	GROUP ID	ID assigned to the cardholder group or employer group.		N/U	P	A	15	79Ø	8Ø4	
215	CARRIER NUMBER	Account Number assigned during installation.		M	P	A	9	8Ø5	813	Required PRMP assigned trading partner ID of MCO/MAO
757-U6	BENEFIT ID	Assigned by processor to identify a set of parameters, benefits, or coverage criteria used to adjudicate a claim.		N/U	P	A	15	814	828	
24Ø	CONTRACT NUMBER	Account Number assigned during installation for segments of business.		N/U	P	A	8	829	836	
212	BENEFIT TYPE	Indicates the type of acceptable claims for the group based on the Benefit setup.		N/U	P	A	1	837	837	
279	MEMBER SUBMITTED	A one-position field indicating the type of member submitted claim		N/U	P	A	1	838	838	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	CLAIM PROGRAM CODE	program used to process this claim.								
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.		N/U	P	A	1	839	839	
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.		N/U	P	A	1	84Ø	84Ø	
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.		N/U	P	A	1	841	841	
241	COPAY MODIFIER ID	Unique drug list ID that is coordinated for use with the clients copay setup. Processor defined codes		N/U	P	A	1Ø	842	851	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.		N/U	P	A	1	852	852	
293	PREFERRED ALTERNATIVE FILE ID	Indicates the preferred alternative file ID number used to determine processing.		N/U	P	A	1Ø	853	862	
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no	S	C	N	2	863	864	If available, report the appropriate value that represents other coverage for the drug/product. COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received Ø3 – Other Coverage Billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed,							

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only. Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.							
291	PLAN BENEFIT CODE	Determines the method by which Insulin and OTC claims are paid. Defined by processor.		N/U	P	A	2	865	866	
8Ø1-Ø1	PLAN TYPE	Identifies the type of plan.	192Ø – Medicaid 193Ø – Medicare If neither MAO nor Wraparound is the primary payer, enter four spaces.	M	P	A	4	867	87Ø	Use 193Ø (Medicare) when only MAO funding is used to pay the drug/product. Use 192Ø (Medicaid) when only Puerto Rico Medicaid funds are used to pay the drug/product If neither, enter spaces COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
SECTION DENOTES PHARMACY CATEGORY:										
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Code qualifying the "Service Provider ID" (2Ø1-B1)	Ø1 – National Provider Identifier (NPI) Ø5 – Medicaid ID if atypical	M	C	A	2	871	872	Required
2Ø1-B1	SERVICE PROVIDER ID	ID assigned to a pharmacy or provider.		M	C	A	15	873	887	Required
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER (ALTERNATE)	Code qualifying the "Service Provider ID" (2Ø1-B1)		N/U	P	A	2	888	889	
2Ø1-B1	SERVICE PROVIDER ID (ALTERNATE)	ID assigned to a pharmacy or provider.		N/U	P	A	15	89Ø	9Ø4	
886	SERVICE PROVIDER CHAIN CODE	Processor specific ID assigned to a chain by processor.		N/U	P	A	7	9Ø5	911	
833-SP	PHARMACY NAME	Pharmacy name.		M	P	A	7Ø	912	981	Required
726-SR	ADDRESS LINE 1	First line of address information.		M	P	A	4Ø	982	1Ø21	Required
727-SS	ADDRESS LINE 2	Second line of address information.		N/U	P	A	4Ø	1Ø22	1Ø61	
728	CITY	Free-form text for city name.		M	P	A	3Ø	1Ø62	1Ø91	Required
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.		M	P	A	2	1Ø92	1Ø93	Required
73Ø	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.		M	P	A	15	1Ø94	11Ø8	Required
887	SERVICE PROVIDER COUNTY CODE	Indicates the county of the pharmacy.		N/U	P	A	3	11Ø9	1111	

ADMINISTRACION DE SEGUROS DE SALUD

23-000456

Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
A93	SERVICE PROVIDER COUNTRY CODE	Indicates the country code of the provider		N/U	P	A	2	1112	1113	
732	TELEPHONE NUMBER	Telephone Number.		N/U	P	N	1Ø	1114	1123	
B1Ø -8A	TELEPHONE NUMBER EXTENSION	Extension of the telephone number.		N/U	P	N	8	1124	1131	
146	PHARMACY DISPENSER TYPE QUALIFIER	Code qualifying the 'Pharmacy Dispenser Type' (29Ø).		N/U	P	A	1	1132	1132	
29Ø	PHARMACY DISPENSER TYPE	Type of pharmacy dispensing product		N/U	P	A	2	1133	1134	
15Ø	PHARMACY CLASS CODE QUALIFIER	Code qualifying the 'Pharmacy Class Code' (289).		N/U	P	A	1	1135	1135	
289	PHARMACY CLASS CODE	Indicates class of the pharmacy.		N/U	P	A	1	1136	1136	
266	IN NETWORK INDICATOR	Indicates if the pharmacy dispensing the prescription is considered in network.		N/U	P	A	1	1137	1137	
545-2F	NETWORK REIMBURSEMENT ID	Field defined by the processor. It identifies the network, for the covered member, used to calculate the reimbursement to the pharmacy.		N/U	P	A	1Ø	1138	1147	
SECTION DENOTES PRESCRIBER CATEGORY:										
466-EZ	PRESCRIBER ID QUALIFIER	Code qualifying the 'Prescriber ID' (411-DB).	Ø1 – National Provider Identifier (NPI) Ø5 – Medicaid ID if atypical	M	C	A	2	1148	1149	Required

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23-00045G

Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
411-DB	PRESCRIBER ID	ID assigned to the prescriber.		M	C	A	15	1150	1164	Required
466-EZ	PRESCRIBER ID QUALIFIER (ALTERNATE)	Code qualifying the 'Prescriber ID' (411-DB).		N/U	P	A	2	1165	1166	
411-DB	PRESCRIBER ID (ALTERNATE)	ID assigned to the prescriber.		N/U	P	A	15	1167	1181	
296	PRESCRIBER TAXONOMY	The taxonomy is defined as a classification scheme that codifies provider type and provider area of specialization.		S	P	A	10	1182	1191	Required when available in the payer's adjudication system.
295	PRESCRIBER CERTIFICATION STATUS	Indicates a provider's certification in the health plan program.		N/U	P	A	2	1192	1193	
716-SY	LAST NAME	Last name.		M	P	A	35	1194	1228	Required
717-SX	FIRST NAME	First name.		M	P	A	35	1229	1263	Required
732	TELEPHONE NUMBER	Telephone Number		M	P	N	10	1264	1273	Required
B10-BA	TELEPHONE NUMBER EXTENSION	Extension of the telephone number.		N/U	C/P	N	8	1274	1281	
466-2E	PRIMARY CARE PROVIDER ID QUALIFIER	Code qualifying the 'Primary Care Provider ID' (421-DL).		N/U	C/P	A	2	1282	1283	
421-DL	PRIMARY CARE PROVIDER ID	ID assigned to the primary care provider. Used when the patient is referred to a secondary care provider.		N/U	C/P	A	15	1284	1298	
716-SY	LAST NAME	Last name.				A	35	1299	1333	

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23-000450

Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
717-SX	FIRST NAME	First name.		NAU	P	A	35	1334	1368	
SECTION DENOTES CLAIM CATEGORY:										
399	RECORD STATUS CODE	Identifies the transaction status as assigned by the processor.	1 – Paid – Code indicating that the transaction was adjudicated using plan rules and was payable. 2 – Rejected – Code indicating that the transaction was denied/rejected. 3 – Reversed – Code indicating that the paid transaction was cancelled. 4 – Adjusted – Code indicating that the previous transaction was changed. 5 – Captured – Code indicating the receipt of the transaction, but no judgment has been made regarding eligibility of the patient or payment. 6 – Reverse – Captured – Code indicating that the captured transaction was cancelled.	M	P	A	1	1369	1369	Required

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23-00045G

Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
218	CLAIM MEDIA TYPE	Claim submission type code.	Blank – Not Specified 1 – POS Claim – A Point-Of-Sale transaction submitted in a real-time mode. 2 – Batch Claim – A non-real-time transaction submitted when an immediate response is not available or required. 3 – Pharmacy Submitted Paper Claim (UCF) – A non-electronic transaction submitted via an NCPDP-developed Universal Claim Form. 4 – Member Submitted Paper Claim (Direct Member Reimbursement (DMR)) – A claim submitted by the member requesting reimbursement 5 – Other – Different from the codes already specified	M	P	A	1	1370	1370	Required
395	PROCESSOR PAYMENT	Provides additional information of the status	Blank – Not Specified	M	P	A	2	1371	1372	PRMP requires "Blank" for this data element

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23-000456

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	CLARIFICATION CODE	of the payment of the claim.								
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	Prescription/Service Reference Number Qualifier	1 – Rx Billing Transaction – A billing for a prescription or OTC drug product. 2 – Service Billing – Transaction is a billing for a professional service performed.	M	C	A	1	1373	1373	Required
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided.		M	C	N	12	1374	1385	Required
436-E1	PRODUCT/ SERVICE ID QUALIFIER	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	36 – NDC	M	C	A	2	1386	1387	Required
4Ø7-D7	PRODUCT/ SERVICE ID	ID of the product dispensed or service provided.		M	C	A	19	1388	1406	Required NDC drug code if a compound drug is being reported; this field should be all zeros.
4Ø1-D1	DATE OF SERVICE	Identifies date that the prescription was filled or professional service rendered or subsequent payer began coverage following Part A expiration in a long-term care setting only.		M	C	N	8	1407	1414	Required CCYYMMDD
578	ADJUDICATION DATE	Date that the claim or adjustment is processed.		M				1415	1422	Required

ADMINISTRACION DE SEGUROS DE SALUD

23 - 000455

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
2Ø3	ADJUDICATION TIME	Time that the claim or adjustment is processed.		N/U	P	N	6	1423	1428	
283	ORIGINAL CLAIM RECEIVED DATE	The date that the pharmacy submitted the claim electronically for a paper claim-matching program.		N/U	P	N	8	1429	1436	
219	CLAIM SEQUENCE NUMBER	Indicates the sequence of this claim within the set of claims submitted.		N/U	P	N	5	1437	1441	
213	BILLING CYCLE END DATE	Cycle end date.		N/U	P	N	8	1442	1449	
239	COMMUNICATION TYPE INDICATOR	For Mail Service Claims Only – Identifies the type of communication used by either prescriber or patient to initiate the request for the fill		N/U	P	A	2	145Ø	1451	
3Ø7-C7	PLACE OF SERVICE	Code identifying the place where a drug or service is dispensed or administered.		N/U	C	N	2	1452	1453	
384-4X	PATIENT RESIDENCE	Code identifying the patient's place of residence.	ØØ – Not Specified	N/U	C	N	2	1454	1455	
419-DJ	PRESCRIPTION ORIGIN CODE	Code indicating the origin of the prescription.	Ø – Not Known	N/U	C	N	1	1456	1456	
278	MEMBER SUBMITTED CLAIM PAYMENT RELEASE DATE	Indicates the date that the member-submitted claim became payable, which could differ from the check date.		N/U	P	N	8	1457	1464	
217	CLAIM DATE RECEIVED IN THE MAIL	Date that the paper claim was received in the mail.		N/U	P	N	8	1465	1472	

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23 - 000456

Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
268	INTERNAL MAIL ORDER PRESCRIPTION/ SERVICE REFERENCE NUMBER	Field designating the internal prescription number assigned by pharmacies.		N/U	P	A	15	1473	1487	
1Ø2-A2	VERSION/ RELEASE NUMBER (OF THE CLAIM)	Code uniquely identifying the transmission syntax and corresponding Data Dictionary		N/U	C	A	2	1488	1489	
218	CHECK DATE	Member Claims – Actual member check date. Nonmember Claims – Pharmacy check date.		N/U	P	N	8	1490	1497	
287	PAYMENT/ REFERENCE ID	Identifies ID assigned by sender to reference individual pharmacy and member reimbursement. Check or EFT trace number.		N/U	P	A	3Ø	1498	1527	
456-EN	ASSOCIATED PRESCRIPTION/ SERVICE REFERENCE NUMBER	Related 'Prescription/Service Reference Number' (4Ø2-D2) to which the service is associated		N/U	C	N	12	1528	1539	
457-EP	ASSOCIATED PRESCRIPTION/ SERVICE DATE	Date of the 'Associated Prescription/Service Reference Number' (456-EN).		N/U	C	N	8	1540	1547	
442-E7	QUANTITY DISPENSED	Quantity dispensed, expressed in metric decimal units		M	C	N	1Ø	1548	1557	Required Quantity dispensed – if a compound drug is being reported, this field should be all zeros.

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23 - 000456

Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
4Ø3-D3	FILL NUMBER	The code indicating whether the prescription is an original or a refill	ØØ – Original dispensing – The first dispensing Ø1 – 99 – Refill number – Number of the replenishment	M	C	N	2	1558	1559	Required Indicates new Rx (zero) or number of refills used.
4Ø5-D5	DAYS SUPPLY	Estimated number of days that the prescription will last.		M	C	N	3	156Ø	1562	Required
414-DE	DATE PRESCRIPTION WRITTEN	Date that the prescription was written.		M	C	N	8	1563	157Ø	Required CCYYMMDD
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	Ø – No Product Selection Indicated 1 – Substitution Not Allowed by Prescriber 2 – Substitution Allowed – Patient Requested Product Dispensed 3 – Substitution Allowed – Pharmacist Selected Product Dispensed 4 – Substitution Allowed – Generic Drug Not in Stock 5 – Substitution Allowed – Brand 6 – Override 7 – Substitution Not Allowed 8 – Substitution Allowed	M	C	A	1	1571	1571	Required

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23-00045G

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			9 – Substitution Allowed By Prescriber, but Plan Requests Brand							
415-DF	NUMBER OF REFILLS AUTHORIZED	Number of refills authorized by the prescriber	ØØ – No refills authorized Ø1 – 99 – Authorized Refill number – with '99' being refills unlimited	M	C	N	2	1572	1573	Required
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.		N/U	C	N	1	1574	1574	
6ØØ-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA – Each GM – Grams ML – Milliliters	M	C	A	2	1575	1576	Required
418-DI	LEVEL OF SERVICE	Coding indicating the type of service that the provider rendered.	ØØ – Not Specified Ø1 – Patient consultation Ø2 – Home delivery Ø3 – Emergency Ø4 – 24 hour service Ø5 – Patient consultation regarding generic product selection Ø6 – In-Home Service	M	C	N	2	1577	1578	Required
343-HD	DISPENSING STATUS	Code indicating that the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory	Blank – Not Specified P – Partial Fill C – Completion of Partial Fill	M	C	A	1	1579	1579	Required

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23-000456

Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		shortages do not allow the full quantity to be dispensed.								
344-HF	QUANTITY INTENDED TO BE DISPENSED	Metric decimal quantity of medication that would be dispensed on original filling if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).		N/U	C	N	10	1580	1589	
460-ET	QUANTITY PRESCRIBED	Amount expressed in metric decimal units.		N/U	C	N	10	1590	1599	
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	Days' supply for metric decimal quantity of medication that would be dispensed on original dispensing if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).		S	C	N	3	1600	1602	Required
254	FILL NUMBER CALCULATED	Code identifying whether the prescription is an original (00) or by refill number (01 – 99).		N/U	P	N	2	1603	1604	
406-D6	COMPOUND CODE	Code indicating whether or not the prescription is a compound.	0 – Not Specified 1 – Not a Compound 2 – Compound	M	C	N	1	1605	1605	Required
996-G1	COMPOUND TYPE	Clarifies the type of compound.		N/U	C	A	2	1606	1607	
452-EH	COMPOUND ROUTE OF ADMINISTRATION	Code for the route of administration of the complete compound mixture.		N/U	C	N	2	1608	1609	

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23-00045

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
995-E2	ROUTE OF ADMINISTRATION	This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture.		M	C	A	11	1610	1620	Required
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	Ø0 – Not Specified Ø1 – International Classification of Diseases (ICD9) Ø2 – International Classification of Diseases-10 (ICD10)	S	C	A	2	1621	1622	Required
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		S	C	A	15	1623	1637	Required
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO)		N/U	C	A	2	1638	1639	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	1640	1654	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO)		N/U	C	A	2	1655	1656	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	1657	1671	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO)		N/U	C	A	2	1672	1673	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	1674	1688	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		N/U	C	A	2	1689	1690	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	1691	17Ø5	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	17Ø6	17Ø7	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	17Ø8	17Ø9	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	171Ø	1711	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1712	1713	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1714	1715	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has		N/U	C	A	2	1716	1717	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		been identified or service has been rendered.								
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1718	1719	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	172Ø	1721	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1722	1723	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1724	1725	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1726	1727	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a		N/U	C	N	2	1728	1729	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		pharmacist to perform a professional service.								
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1730	1731	
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1732	1733	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1734	1735	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1736	1737	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1738	1739	
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1740	1741	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1742	1743	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service		N/U	C	N	2	1744	1745	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1746	1747	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered		N/U	C	A	2	1748	1749	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	175Ø	1751	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1752	1753	

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23-00045G

Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service		N/U	C	A	2	1754	1755	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1756	1757	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service		N/U	C	A	2	1758	1759	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service		N/U	C	N	2	176Ø	1761	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service		N/U	C	A	2	1762	1763	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1764	1765	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1766	1767	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1768	1769	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1770	1771	
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1772	1773	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1774	1775	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1776	1777	

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23-00045C

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	1778	1779	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	1780	1798	
878	REJECT OVERRIDE CODE	Indicates the reason for paying a claim when override is used.		N/U	P	A	1	1799	1799	
511-FB	REJECT CODE	Code indicating the error encountered		N/U	C	A	3	1800	1802	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	1803	1805	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	1806	1808	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	1809	1811	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	1812	1814	
SECTION DENOTES WORKER'S COMPENSATION CATEGORY:										
435-DZ	CLAIM/REFERENCE ID	Identifies the claim number assigned by Worker's Compensation Program.		N/U	C	A	30	1815	1844	
434-DY	DATE OF INJURY	Date on which the injury occurred.		N/U	C	N	8	1845	1852	
SECTION DENOTES PRODUCT CATEGORY:										
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define		N/U	P	A	1	1853	1853	

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23-00045G

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		the database used for identifying the product.								
397	PRODUCT/ SERVICE NAME	Product or Service Description or Product Label Name		N/U	P	A	3Ø	1854	1883	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.		N/U	P	A	3Ø	1884	1913	
6Ø1-24	PRODUCT STRENGTH	The strength of the product.		N/U	P	A	15	1914	1928	
243	DOSAGE FORM CODE	Dosage form code for product identified.		N/U	P	A	4	1929	1932	
	FILLER			N/U	P	A	8	1933	194Ø	
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.		N/U	P	N	1	1941	1941	
273	MAINTENANCE DRUG INDICATOR	Indicates if the drug is a maintenance drug under the client's benefit plan.		N/U	P	A	1	1942	1942	
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.		N/U	P	A	1	1943	1943	
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.		N/U	P	A	1	1944	1944	
287	PRESCRIPTION OVER THE COUNTER INDICATOR	The indicator that specifies this prescription is a federal/legend (Rx prescription only) or non-prescription drug (OTC).		N/U	P	A	1	1945	1945	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.	Ø9 – Encounters	M	C	N	2	1946	1947	Required
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.		N/U	C	N	2	1948	1949	
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.		N/U	C	N	2	195Ø	1951	
25Ø	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.		N/U	P	A	1	1952	1952	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.		N/U	P	A	1	1953	1953	
6Ø1-19	PRODUCT CODE	Code identifying the product being reported		N/U	P	A	17	1954	197Ø	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.		N/U	P	A	1	1971	1971	
6Ø1-19	PRODUCT CODE	Code identifying the product being reported.		N/U	P	A	17	1972	1988	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.		N/U	P	A	1	1989	1989	
6Ø1-19	PRODUCT CODE	Code identifying the product being reported.		N/U	P	A	17	199Ø	2ØØ6	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.		N/U	P	A	1	2ØØ7	2ØØ7	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
294	PRESCRIBED DAYS SUPPLY	Indicates the original days' supply of the prescription. Applies to internal Mail Service only.		N/U	P	N	3	2Ø08	2Ø1Ø	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø11	2Ø11	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø12	2Ø28	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø29	2Ø29	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø3Ø	2Ø46	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø47	2Ø47	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø48	2Ø64	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø65	2Ø65	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø66	2Ø82	
SECTION DENOTES FORMULARY CATEGORY:										
267	FORMULARY STATUS	Indicates the Formulary status of the Drug.		N/U	P	A	1	2Ø83	2Ø83	
221	CLIENT FORMULARY FLAG	Indicates that the client has a formulary.		N/U	P	A	1	2Ø84	2Ø84	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter, from formulary file as defined by processor.		N/U	P	A	8	2085	2092	
256	FORMULARY FILE ID	Identifies the formulary ID used during adjudication of the claim.		N/U	P	A	15	2093	21Ø7	
255	FORMULARY CODE TYPE	Indicates how the Formulary Benefit is set up. As defined by processor.		N/U	P	A	1	21Ø8	21Ø8	
SECTION DENOTES PRICING CATEGORY:										
5Ø6-F6	INGREDIENT COST PAID	Drug ingredient cost paid included in the "Total Amount Paid" (5Ø9-F9).		M	C	D	8	2109	2116	Required
5Ø7-F7	DISPENSING FEE PAID	Total amount to be paid by the claims processor.		M	C	D	8	2117	2124	Required
894	TOTAL AMOUNT PAID BY MCO or MAO	Total amount of the prescription regardless of party responsible for payment.		M	P	D	8	2125	2132	Required
523-FN	AMOUNT ATTRIBUTED TO SALES TAX	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to sales tax paid.		N/U	C	D	8	2133	214Ø	
5Ø5-F5	PATIENT PAY AMOUNT	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy. the patient's total cost share, including copayments, amounts applied to deductible, over		M	C	D	8	2141	2148	Required

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		maximum amounts, penalties, etc.								
518-FI	AMOUNT OF COPAY	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to per prescription coinsurance.		S	C	D	8	2149	2156	Required
572-4U	AMOUNT OF COINSURANCE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of a Brand product.		S	C	D	8	2157	2164	Required
519-FJ	AMOUNT ATTRIBUTED TO PRODUCT SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to per prescription copay		N/U	C	D	8	2165	2172	
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to a periodic deductible.		N/U	C	D	8	2173	2180	
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the processing fee imposed by the processor.		N/U	C	D	8	2181	2188	
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's provider network selection.		N/U	C	D	8	2189	2196	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/ BRAND DRUG	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of Brand product.		N/U	C	D	8	2197	22Ø4	
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of Non-Preferred Formulary product.		N/U	C	D	8	2205	2212	
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/ BRAND NON-PREFERRED FORMULARY SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of a Brand Non-Preferred Formulary product.		N/U	C	D	8	2213	222Ø	
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient being in the coverage gap (i.e., donut hole). A coverage gap is defined as the period or amount during which the previous coverage ends and before an additional coverage begins.		N/U	C	D	8	2221	2228	
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a Maximum Allowable Cost (MAC) program		N/U	P	A	1	2229	2229	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing		N/U	P	A	2	223Ø	2231	
26Ø	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product, as defined by processor.		N/U	P	A	1	2232	2232	
284	OUT OF POCKET APPLY AMOUNT	Amount applied to the out of pocket expense.		N/U	P	D	8	2233	224Ø	
2Ø9	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.		N/U	P	D	9	2241	2249	
21Ø	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.		N/U	P	D	9	225Ø	2258	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor		N/U	P	D	9	2259	2267	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor		N/U	P	D	9	2268	2276	
43Ø-DU	GROSS AMOUNT DUE	Total price claimed from all sources.		M	C	D	8	2277	2284	Required Amount billed to the MCO (Amount being billed by the provider to the MCO). MASK 9999999V99 zero filled, no sign.
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.		N/U	P	D	9	2285	2293	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
409-D9	INGREDIENT COST SUBMITTED	Submitted product component cost of the dispensed prescription. This amount is included in the "Gross Amount Due (430-DU).		S	C	D	8	2294	2301	Send if Available
426-DQ	USUAL AND CUSTOMARY CHARGE	Amount charged to cash customers for the prescription exclusive of sales tax or other amounts claimed		S	C	D	8	2302	2309	Send if Available
558-AW	FLAT SALES TAX AMOUNT PAID	Flat sales tax paid which is included in the "Total Amount Paid" (509-F9).		S	C	D	8	2310	2317	Send if Available
559-AX	PERCENTAGE SALES TAX AMOUNT PAID	Amount of percentage sales tax paid which is included in the "Total Amount Paid" (509- F9).		N/U	C	D	8	2318	2325	
560-AY	PERCENTAGE SALES TAX RATE PAID	Percentage sales tax rate used to calculate "Percentage Sales Tax Amount Paid" (559-AX)		N/U	C	D	7	2326	2332	
561-AZ	PERCENTAGE SALES TAX BASIS PAID	Code indicating the percentage sales tax.		N/U	C	A	2	2333	2334	
521-FL	INCENTIVE AMOUNT PAID	Amount represents the contractually agreed upon incentive fee paid for specific services rendered Amount is included in the "Total Amount Paid" (509-F9).		N/U	C	D	8	2335	2342	
562-J1	PROFESSIONAL SERVICE FEE PAID	Amount representing the contractually agreed upon fee for professional services rendered. This amount is included in the		N/U	C	D	8	2343	2350	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		"Total Amount Paid" (5Ø9-F9).								
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565- J4).	Ø1 – Delivery Cost Ø2 – Shipping Cost Ø3 – Postage Ø4 – Administrative Cost Ø5 – Incentive Ø6 – Cognitive Service Ø7 – Drug Benefit Ø8 – Compound Preparation Cost Submitted Ø9 – Sales Tax 1Ø – Medicaton Administration	M	C	A	2	2351	2352	Required
565-J4	OTHER AMOUNT PAID	Amount paid for additional costs claimed in 'Other Amount Claimed Submitted' (48Ø-H9).		S	C	D	8	2353	236Ø	Required
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565-J4).	See first occurrence of 564-J3 above.	S	C	A	2	2361	2362	Required
565-J4	OTHER AMOUNT PAID	Amount paid for additional costs claimed in 'Other Amount Claimed Submitted' (48Ø-H9).		S	C	D	8	2363	237Ø	Required
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565- J4).	See first occurrence of 564-J3 above.	S	C	A	2	2371	2372	Required
565-J4	OTHER AMOUNT PAID	Amount paid for additional costs claimed in 'Other Amount		S	C	D	8	2373	238Ø	Required

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		Claimed Submitted' (480-H9).								
586-J5	OTHER PAYER AMOUNT RECOGNIZED	Total amount recognized by the processor of any payment from another source.		N/U	C	D	8	2381	2388	Not Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the 'Other Payer-Patient Responsibility Amount (352-NQ)'	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer.	S	C	A	2	2389	239Ø	Required COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer. Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. 11 – Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer. 12 – Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as							

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			reported by previous payer. 13 – Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	2391	2400	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)"	Same Values as Above.	S	C	A	2	2401	2402	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	2403	2412	Required COB/TPL
28*	NET AMOUNT DUE	Net amount paid to provider by the payer or net amount due from the client to the payer, determined by trading partner agreement.		M	P	D	8	2413	2420	Required
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (506-F6)		N/U	C	N	2	2421	2422	
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT	Amount in dollars met by the patient/family in a deductible plan		N/U	C	D	8	2423	2430	
513-FD	REMAINING DEDUCTIBLE AMOUNT	Amount not met by the patient/family in the deductible plan.		N/U	C	D	8	2431	2438	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
514-FE	REMAINING BENEFIT AMOUNT	Amount remaining in a patient/family plan with a periodic maximum benefit.		N/U	C	D	8	2439	2446	
242	COST DIFFERENCE AMOUNT	Difference between client contracted amount and the pharmacy or member submitted amount.		N/U	P	D	8	2447	2454	
249	EXCESS COPAY AMOUNT	Amount of the copay that exceeds the approved amount for this claim.		N/U	P	D	8	2455	2462	
277	MEMBER SUBMIT AMOUNT	Ingredient cost as submitted by member (paper claims only).		N/U	P	D	8	2463	2470	
265	HOLD HARMLESS AMOUNT	Amount payable to member when paper claims amount exceeds Pharmacy Network Reimbursement.		N/U	P	D	8	2471	2478	
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM	Amount to be collected from the patient that is included in "Patient Pay Amount" (505-F5) that is due to the patient exceeding a periodic benefit maximum.		N/U	C	D	8	2479	2486	
346-HH	BASIS OF CALCULATION – DISPENSING FEE	Code indicating how the reimbursement amount was calculated for "Dispensing Fee Paid" (507-F7).		N/U	C	A	2	2487	2488	
347-HJ	BASIS OF CALCULATION – COPAY	Code indicating how the copay reimbursement amount was calculated for "Dispensing Fee Paid" (505-F5).		N/U	C	A	2	2489	2490	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
348-HK	BASIS OF CALCULATION – FLAT SALES TAX	Code indicating how the reimbursement amount was calculated for "Flat Sales Tax Amount Paid" (558-AW).		N/U	C	A	2	2491	2492	
349-HM	BASIS OF CALCULATION – PERCENTAGE SALES TAX	Code indicating how the reimbursement amount was calculated for "Percentage Sales Tax Amount Paid" (559-AX).		N/U	C	A	2	2493	2494	
573-4V	BASIS OF CALCULATION – COINSURANCE	Code indicating how the coinsurance reimbursement amount was calculated for "Patient Pay Amount" (559-AX).		N/U	C	A	2	2495	2496	
557-AV	TAX EXEMPT INDICATOR	Code indicating that the payer and/or the patient is exempt from taxes.		N/U	C	A	1	2497	2497	
285	PATIENT FORMULARY REBATE AMOUNT	Credit that the patient receives on this claim from the drug manufacturer.		N/U	P	D	8	2498	2505	
276	MEDICARE RECOVERY INDICATOR	Field to indicate if Medicare was billed in order to recover funds for current or previous claims billed to the client.		N/U	P	A	1	2506	2506	
275	MEDICARE RECOVERY DISPENSING INDICATOR	Field to indicate if days' supply on prescription was reduced due to plan limits.		N/U	P	A	1	2507	2507	
286	PATIENT SPEND DOWN AMOUNT	Claim dollars applied to patient's spend down account (example: Flexible Spending Account).		N/U	P	D	8	2508	2515	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
263	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT APPLIED	Health Care Reimbursement Account Amount Applied		N/U	P	D	8	2516	2523	
564-	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT REMAINING	Client-defined benefit that provides funds to patients that can be used to offset Out of Pocket expenses.		N/U	P	D	8	2524	2531	
2Ø7	ADMINISTRATIVE FEE EFFECT INDICATOR	Indicates how the transaction should be counted for administrative fee determination.		N/U	P	A	1	2532	2532	
2Ø6	ADMINISTRATIVE FEE AMOUNT	Administrative fee charge per claim.		N/U	P	D	4	2533	2536	
269	INVOICED AMOUNT	Amount invoiced for this transaction. Determined by Processor		N/U	P	D	11	2537	2547	
	FILLER			N/U	P	A	1Ø	2548	2557	
126-UC	SPENDING ACCOUNT AMOUNT REMAINING	The balance from the patient's spending account after this transaction was applied.		N/U	C	D	8	2558	2565	
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT	The amount from the health plan-funded assistance account for the patient that was applied to reduce 'Patient Pay Amount' (5Ø5-F5). This amount is used in Healthcare Reimbursement Account (HRA) benefits only. This		N/U	C	D	8	2566	2573	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		field is always a negative amount or zero.								
SECTION DENOTES PRIOR AUTHORIZATION CATEGORY:										
461-EU	PRIOR AUTHORIZATION TYPE CODE	Code clarifying the 'Prior Authorization Number Submitted' (462-EV) or benefit/plan exemption.		N/U	C	N	2	2574	2575	
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Number submitted by the provider to identify the prior authorization.		N/U	C	N	11	2576	2586	
498-PY	PRIOR AUTHORIZATION NUMBER – ASSIGNED	Unique number identifying the prior authorization assigned by the processor.		N/U	P	N	11	2587	2597	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.		N/U	P	N	2	2598	2599	
SECTION DENOTES ADJUSTMENT CATEGORY:										
2Ø4	ADJUSTMENT REASON CODE	Reason for adjustment.		N/U	P	N	3	26ØØ	26Ø2	
2Ø5	ADJUSTMENT TYPE	Type of adjustment.		N/U	P	A	1	26Ø3	26Ø3	
897	TRANSACTION ID CROSS REFERENCE	For reversals, ID associated with original claim.		M	P	A	3Ø	26Ø4	2633	Required The TCN of the encounter being voided by this reversal is entered here.
SECTION DENOTES COORDINATION OF BENEFITS CATEGORY:										
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier		S	P	D	8	2634	2641	If available in payer's system.

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
										COB/TPL
245	ELIGIBILITY COB INDICATOR	COB code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient. 2 – Payer is Secondary – Plan is second payer for patient. 3 – Payer is Tertiary – Plan is third payer for patient.	S	P	A	1	2642	2642	Required when available in the payer's adjudication system. COB/TPL
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed	S	P	A	1	2643	2643	If the MAO/MCO has COB Carrier Amount available. COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			out of a retail pharmacy.							
232	COB PRIMARY PAYER ID	ID assigned to primary payer.	**MAOSNP** = When MAO pays for a drug. **MEDICAID** = When PR Medicaid funding is used to pay for the drug. **MEDB** = Medicare Part B (in the event that Part D does not cover). **MEDD** = Medicare Part D. **MEDIGAP** = An insurance plan that covers only Medicare/MAO cost sharing. **COMMERCIAL** = When the MAO Member has a private health insurance plan that must consider payment of a drug before the MAO can consider payment of the drug/product. **TRICARE** = If the MAO Member is a veteran where TRICARE must pay or deny the pharmacy claim before the MAO can consider paying for the drug	M	C/P	A	10	2644	2653	Required COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	FILLER			N/U	P	A	8	2654	2661	
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		S	C/P	D	8	2662	2669	Required – report the payment associated to the primary payer. The MAO SNP would be considered the primary payer when the Platino Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibility). COB/TPL
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		S	C/P	D	8	2670	2677	Required COB/TPL
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		S	C/P	D	8	2678	2685	Required COB/TPL
230	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		S	C/P	D	8	2686	2693	Required COB/TPL
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	**MAOSNP** = When the MAO pays for a drug as a secondary payer to a Commercial insurance plan or TRICARE. **MEDIGAP** = When the MAO Member has a 'Medicare gap' insurance as a commercial	S	C/P	A	10	2694	2703	Required when the MAO/MCO and another insurance plan or Medicaid paid for the drug or cost sharing. COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			insurance plan that covers Medicare or MAO cost sharing. Medicare gap insurance is always secondary to Medicare or an MAO. **MEDICAID** = When the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug. MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product. The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** = When the Platino Member has a private health insurance plan that must consider payment of a drug/product, report							

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			'COMMERCIAL' as the Secondary Payer ID in Field #238. **TRICARE** = When the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim.							
	FILLER			N/U	P	A	8	27Ø4	2711	
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		S	C/P	D	8	2712	2719	Required when the Secondary Payer paid for the drug/product or the Platino Member's cost sharing. COB/TPL
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		S	C/P	D	8	272Ø	2727	Required when there is a Secondary Payer deductible that was assessed on the drug/product. COB/TPL
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		S	C/P	D	8	2728	2735	Required when there is a Secondary Payer coinsurance that was assessed on the drug/product. COB/TPL
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		S	C/P	D	8	2736	2743	Required when there is a Secondary Payer copayment

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
										that was assessed on the drug/product. COB/TPL
SECTION DENOTES REFERENCE CATEGORY:										
896	TRANSACTION ID	Internally assigned unique claim ID by the payer		M	P	A	3Ø	2744	2773	Required Every claim in the file must contain the unique internal Transaction ID (TCN) assigned by PBM during adjudication.
5Ø3-F3	AUTHORIZATION NUMBER	Number assigned by the processor to identify an authorized transaction.		N/U	P	A	2Ø	2774	2793	
224	CLIENT SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by client		N/U	P	A	5Ø	2794	2843	
396	PROCESSOR SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by processor.		N/U	P	A	5Ø	2844	2893	
997-G2	CMS PART D DEFINED QUALIFIED FACILITY	Indicates that the patient resides in a facility that qualifies for the CMS Part D benefit.		N/U	C	A	1	2894	2894	
SECTION DENOTES FIELDS ADDED IN VERSIONS CATEGORY:										
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the Benefit Stage Amount (394-MW).	Ø1 – Deductible Ø2 – Initial Benefit Ø3 – Coverage Gap (donut hole) Ø4 – Catastrophic Coverage	M	C	A	2	2895	2896	Required COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan). 6Ø – Not paid under Part D. 61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only. 62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only. 63 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid under Medicaid benefit only of the Medicare/Medicaid (MMP) plan. 7Ø – Part D drug not paid by Part D plan benefit; paid by the beneficiary under plan-sponsored negotiated pricing. 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit.							

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend but is covered by the Part D plan							
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier (393-MV).		M	C	D	8	2897	29Ø4	Required COB/TPL
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).		N/U	C	A	2	29Ø5	29Ø6	
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier (393-MV).		N/U	C	D	8	29Ø7	2914	
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW)		N/U	C	A	2	2915	2916	
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).		N/U	C	D	8	2917	2924	
393-MV	BENEFIT STAGE QUALIFIER	The amount of claim allocated to the Medicare stage identified by the		N/U	C	A	2	2925	2926	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		'Benefit Stage Qualifier (393-MV).								
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier (393-MV).		N/U	C	D	8	2927	2934	
699-ZG	INVOICED DATE	The date that the claim was included on an invoice.		N/U	P	N	8	2935	2942	
691-ZH	OUT OF POCKET REMAINING AMOUNT	Dollars remaining until patient is totally in benefit, paying no out of pocket expenses.		N/U	P	D	8	2943	2950	
302-C2	CARDHOLDER ID (ALTERNATE)	Insurance ID assigned to the cardholder or identification number used by the plan.		N/U	P	A	20	2951	2970	
692-ZJ	NUMBER OF GENERIC MANUFACTURERS	Number of manufacturers that produce this generic drug provided by drug compendium.		N/U	P	N	3	2971	2973	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	2974	2975	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	2976	2994	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	2995	2996	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service)		N/U	C	A	19	2997	3Ø15	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3Ø16	3Ø17	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service)		N/U	C	A	19	3Ø18	3Ø36	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3Ø37	3Ø38	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service)		N/U	C	A	19	3Ø39	3Ø57	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3Ø58	3Ø59	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service)		N/U	C	A	19	3Ø6Ø	3Ø78	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3079	3080	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	3081	3099	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3100	3101	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service)		N/U	C	A	19	3102	3120	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3121	3122	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service)		N/U	C	A	19	3123	3141	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)"	Blank – Not Specified 01 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer	S	C	A	2	3142	3143	Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer. Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer. Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health							COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. 11 – Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer. 12 – Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer. 13 – Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer		S	C	D	1Ø	3144	3153	Required COB/TPL
351-NP	OTHER PAYER-PATIENT	Code qualifying the "Other Payer-Patient	See 351-NP above for codes	S	C	A	2	3154	3155	Required

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	RESPONSIBILITY AMOUNT QUALIFIER	Responsibility Amount (352-NQ)".								COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	3156	3165	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3166	3167	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	3168	3177	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3178	3179	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	3180	3189	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3190	3191	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	3192	3201	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY	Code qualifying the "Other Payer-Patient	See 351-NP above for codes.	S	C	A	2	3202	3203	Required COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	AMOUNT QUALIFIER	Responsibility Amount (352-NQ)"								
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	3204	3213	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)"	See 351-NP above for codes.	S	C	A	2	3214	3215	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer		S	C	D	10	3216	3225	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)"	See 351-NP above for codes.	S	C	A	2	3226	3227	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	3228	3237	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)"	See 351-NP above for codes.	S	C	A	2	3238	3239	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer		S	C	D	10	3240	3249	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3250	3251	Required COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	AMOUNT QUALIFIER									
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	3252	3261	Required COB/TPL
A37	SPECIALTY CLAIM INDICATOR	Indicates whether a claim was filled by a specialty pharmacy or a specialty drug.		N/U	P	A	1	3262	3262	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims, a processor-specified list.		N/U	P	A	3	3263	3265	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims, a processor-specified list.		N/U	P	A	3	3266	3268	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims, a processor-specified list.		N/U	P	A	3	3269	3271	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims, a processor-specified list.		N/U	P	A	3	3272	3274	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims, a processor-specified list.		N/U	P	A	3	3275	3277	
A39	COPAY WAIVER AMOUNT	Dollar amount funded by third party for a copay waiver program where a client funds a portion of their copay amount if they select a certain drug		N/U	P	D	8	3278	3285	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
A33-ZX	CMS PART D CONTRACT ID	Designation assigned by CMS that identifies a specific Medicare Part D sponsor		N/U	P	A	5	3286	329Ø	
A34-ZY	MEDICARE PART D PLAN BENEFIT PACKAGE (PBP)	Identifier assigned by CMS of a particular plan benefit package (Benefit Category) within a Medicare Part D contract.		N/U	P	N	3	3291	3293	
A73	MEDICARE DRUG COVERAGE CODE	Code to indicate if the claim was processed under the Part D Drug Benefit, the Part B Drug Benefit, or does not apply.		N/U	P	A	2	3294	3295	
	FILLER			N/U	P	A	423	3296	37ØØ	

Note: "COB/TPL" indicates that further directions can be found in Appendix A: Discussion of MAO COB/TPL Reporting.

4.2.1 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD1

Table 5 – Post Adjudication History Compound Detail Record1

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	CD – Post Adjudication History Compound Detail Record1.	M	P	A	2	1	2	Required
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	Prescription/Service Reference Number Qualifier	1 – Rx Billing Transaction A billing for a prescription or OTC drug product.	M	C	A	1	3	3	Required

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			2 – Service Billing – Transaction is a billing for a professional service performed.							
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided		M	C	N	12	4	15	Required
477-EC	COMPOUND INGREDIENT COMPONENT COUNT	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		M	C	N	2	16	17	Required
SECTION DENOTES FIRST INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank – Not Specified Ø1 – UPC Ø2 – HRI Ø3 – NDC Ø4 – HIBCC 11 – NAPPI 12 – GTIN 15 – GCN 28 – FDB Med Name ID 29 – FDB Routed Med ID 3Ø – FDB Routed Dosage Form Med ID 31 – FDB Med ID	M	C	A	2	18	19	Required

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			32 – GCN_SEQ_NO 33 – HICL_SEQ_NO 99 – Other							
488-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.		M	C	A	19	20	38	Required If a compound drug is being reported, this is the NDC of the FIRST component of the compound drug
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.		S	C	N	14	39	52	Required Amount expressed in metric decimal units of the product included in the compound mixture. MASK 9(7)V999 zero filled, no sign.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).		S	C	D	8	53	60	Required
490-UE	COMPOUND INGREDIENT	Code indicating the method by which the drug cost of an ingredient	00 – Default			N	2	61	62	Required

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
	BASIS OF COST DETERMINATION	used in a compound was calculated	Ø1 – AWP (Average Wholesale Price) Ø2 – Local Wholesaler Ø3 – Direct Ø4 – EAC (Estimated Acquisition Cost) Ø5 – Acquisition Ø6 – MAC (Maximum Allowable Cost) Ø7 – Usual & Customary Ø8 – 340B/ Disproportionate Share Pricing/Public Health Service Ø9 – Other – Different from those implied or specified 1Ø – ASP (Average Sales Price) 11 – AMP (Average Manufacturer Price) 12 – WAC (Wholesale Acquisition Cost) 13 – Special Patient Pricing 14 – Cost basis on un-reportable quantities							

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			15 – Free product or no associated cost							
221	CLIENT FORMULARY FLAG	Indicates that the client has a formulary.	Blank – Not specified Y – Yes N – No	S	P	A	1	63	63	Indicates that the NDC for the FIRST component of the compound drug is not recognized by PRMP but the MCO covered the drug Value 'Y'
397	PRODUCT/ SERVICE NAME	Product or Service Description or Product Label Name.		N/U	P	A	3Ø	64	93	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.		N/U	P	A	3Ø	94	123	
6Ø1-24	PRODUCT STRENGTH	The strength of the product.		N/U	P	A	1Ø	124	133	
243	DOSAGE FORM CODE	Dosage form code for product identified.		N/U	P	A	4	134	137	
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1 – First DataBank 2 – Medi-Span Product Line 3 – Micromedex/ Medical Economics 4 – Processor Developed 5 – Other 6 – Redbook 7 – Multum	S	P	N	1	138	138	Required

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	ØØ – Not specified 1 – Single Source 2 – Authorized Generic (aka "Branded Generic") 3 – Generic 4 – Over the Counter 5 – Multi-source Brand	S	P	N	1	139	139	
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank – Not Specified I – Drug on Formulary; Non-Preferred J – Drug not on Formulary; Non-Preferred K – Drug not on Formulary; Preferred N – Drug not on Formulary; Neutral P – Drug on Formulary Q – Drug not on Formulary T – Drug on Formulary; Preferred Y- Drug on Formulary, Neutral	S	P	A	1	140	140	
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is		S	P	A	1	141	141	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
		associated with a specific drug category.								
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank – Not Specified 1 – Schedule I Substance (no known use) 2 – Schedule II Narcotic Substances 3 – Schedule III Narcotic Substances 4 – Schedule IV Substances 5 – Schedule V Substances	S	P	A	1	142	142	
25Ø	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration	Blank – Not Specified Ø – Was Drug Efficacy Study Implementation (DESI) – At One Time But No Longer 1 – Drug Efficacy Study Implementation (DESI) Drug	S	P	A	1	143	143	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line	S	P	A	1	144	144	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – Nine-digit NDC A – American Hospital Formulary Service C – Contracting Organization G – First DataBank GCN Sequence Number H – First DataBank HICL Sequence Number M – Manufacturer (PICO) Assigned Code N – Eleven-digit NDC O – UPC							

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			P – Product group T – First DataBank Therapeutic Class Code, Specific U – Universal System of Classification Code V – All products used Z – Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		S	P	A	17	145	161	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the 'Product Code' (6Ø1-18) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier	S	P	A	1	162	162	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			8 – First DataBank Medication Identifier 9 – Nine-digit NDC A – American Hospital Formulary Service C – Contracting Organization G – First DataBank GCN Sequence Number H – First DataBank HICL Sequence Number M – Manufacturer (PICD) Assigned Code N – Eleven-digit NDC O – UPC P – Product group T – First DataBank Therapeutic Class Code, Specific U – Universal System of Classification Code V – All products used Z – Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		S	P	A	17	163	179	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the	Blank – Not Specified	S	P	A	1	18Ø	18Ø	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
		Product Code (6Ø1-18) field.	1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – Nine-digit NDC A – American Hospital Formulary Service C – Contracting Organization G – First DataBank GCN Sequence Number H – First DataBank HICL Sequence Number							

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			M – Manufacturer (PICO) Assigned Code N – Eleven-digit NDC O – UPC P – Product group T – First DataBank Therapeutic Class Code, Specific U – Universal System of Classification Code V – All products used Z – Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		S	P	A	17	181	197	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug	Blank – Not specified 1 – Yes 2 – No	S	P	A	1	198	198	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID	S	P	A	1	199	199	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported		S	P	A	17	2ØØ	216	
6Ø1-25	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization	S	P	A	1	217	217	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			D – First DataBank Therapeutic Class code, Generic E – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICO) Assigned Code U – Universal System of Classification Code Z – Mutually Agreed Upon Code							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported		S	P	A	17	218	234	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage	S	P	A	1	235	235	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization D – First DataBank Therapeutic Class code, Generic E – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICO) Assigned Code U – Universal System of Classification Code Z – Mutually Agreed Upon Code							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		S	P	A	17	236	252	
601-28	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (601-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line	S	P	A	1	253	253	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization D – First DataBank Therapeutic Class code, Generic E – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICC) Assigned Code							

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			U – Universal System of Classification Code Z – Mutually Agreed Upon Code							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported		S	P	A	17	254	27Ø	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	Ø – Not Specified 1 – Not Unit Dose – Indicates that the product is not being dispensed in special unit dose packaging 2 – Manufacturer Unit Dose – A code used to indicate a distinct dose as determined by the manufacturer. 3 – Pharmacy Unit Dose – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose. 4 – Pharmacy Unit Dose Patient Compliance Packaging 5 – Pharmacy Multi-drug Patient	S	C	N	1	271	271	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Compliance Packaging. 6 – Remote Device Unit Dose – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7 – Remote Device Multi-drug Compliance – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8 – Manufacturer Unit of Use Package (not unit dose) – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6ØØ -2B	UNIT OF MEASURE	NCPDP standard product billing codes	EA – Each GM – Grams ML – Milliliters	S	C	A	2	272	273	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	ØØ – Not Specified Ø1 – Prior Authorization Ø2 – Medical Certification Ø3 – EPSDT (Early Periodic Screening Diagnosis Treatment) Ø4 – Exemption from Copay and/or Consurance Ø5 – Exemption from RX Ø6 – Family Planning Indicator Ø7 – TANF (Temporary Assistance for Needy Families) Ø8 – Payer Defined Exemption	S	P	N	2	274	275	
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank – Not Specified Y – Reduced to MAC pricing N – Not reduced to MAC pricing	S	P	A	1	276	275	
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted	Blank – Not Specified Ø1 – Average Wholesale Price	S	P	A	2	277	276	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
		is calculated based on client pricing.	Ø2 – Acquisition Cost (ACQ) Ø3 – Manufacturer Direct Price Ø4 – Federal Upper Limit (FUL) Ø5 – Average Generic Price Ø6 – Usual & Customary Ø7 – Submitted Ingredient Cost Ø8 – State MAC Ø9 – Unit 1Ø – Usual & Customary or Copay							
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6)	Blank – Not Specified Ø1 – UPC Ø2 – HRI Ø3 – NDC Ø4 – HIBCC Ø6 – DUR/PPS Ø7 – CPT4 Ø8 – CPT5 Ø9 – HCPCS 11 – NAPPI 12 – GTIN 14 – GPI 15 – GCN 16 – GFC 17 – DDID	S	C	A	2	279	28Ø	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			18 – First DataBank SmartKey 19 – Truven/ Micromedex Generic Master (GM) 20 – ICD9 21 – ICD10 23 – NCCI 24 – SNOMED 25 – CDT 26 – DSM IV 27 – ICD10-PCS 28 – FDB Med Name ID 29 – FDB Routed Med ID 30 – FDB Routed Dosage Form Med ID 31 – FDB Med ID 32 – GCN_SEQ_NO 33 – HICL_SEQ_NO 35 – LOINC 37 – AHFS 38 – SCD 39 – SBD 40 – GPCK 41 – BPCK 99 – Other							

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		S	C	A	15	281	299	
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product, as defined by processor.		S	P	A	1	300	300	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank – Not Specified 1 – Medicare Part B (Plan Cutback) – A reduction in a quantity of a medical service covered by Medicare Part B. 2 – Medicare Part B with days' supply cutback – A reduction in the days' supply of a service/drug covered by Medicare Part B. C – Net Check limit cutback – A reduction in the net amount of a check. D – Days' Supply cutback – A reduction in the days' supply. I – Ingredient Cost cutback – A	S	P	A	1	301	301	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			reduction in the ingredient cost. Q – Quantity cutback – A reduction in the quantity.							
888	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter from formulary file as defined by processor.		S	P	A	8	302	309	
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.		S	P	D	9	310	318	
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.		S	P	D	9	319	327	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.		S	P	D	9	328	336	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.		S	P	D	9	337	345	
27*	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.		S	P	D	9	346	354	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (505-F6).	00 – Not Specified 01 – Ingredient Cost Paid as Submitted 02 – Ingredient Cost Reduced to AWP Pricing	S	C	N	2	355	356	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or 'Z' to put in the flat

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Ø3 – Ingredient Cost Reduced to AWP Less X% Pricing Ø4 – Usual & Customary Paid as Submitted ØS – Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary Ø6 – MAC Pricing Ingredient Cost Paid Ø7 – MAC Pricing Ingredient Cost Reduced to MAC Ø8 – Contract Pricing Ø9 – Acquisition Pricing 1Ø – ASP (Average Sales Price) 11 – AMP (Average Manufacturer Price) 12 – 34ØB/ Disproportionate Share/Public Health Service Pricing 13 – WAC (Wholesale Acquisition Cost) 14 – Other Payer-Patient Responsibility Amount							file created by the translator. Ø8 = 'C' which is for capitated Ø1 = 'F' which is for FFS 14 = 'T' which is TPL ØØ = 'Z' which is for Zero billed/Provider did not charge

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			15 – Patient Pay Amount 16 – Coupon Payment 17 – Special Patient Reimbursement 18 – Direct Price (DP) 19 – State Fee Schedule (SFS) Reimbursement 20 – National Average Drug Acquisition Cost (NADAC) 21 – State Average Acquisition Cost (AAC) 22 – Ingredient cost paid based on submitted Basis of Cost Free Product							
285	PATIENT FORMULARY REBATE AMOUNT	Credit that the patient receives on this claim from the drug manufacturer		S	P	D	8	357	364	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
SECTION DENOTES SECOND INGREDIENT: *SAME AS THE FIRST INGREDIENT*										
SECTION DENOTES THIRD INGREDIENT:										
SECTION DENOTES FOURTH INGREDIENT:										
SECTION DENOTES FIFTH INGREDIENT:										
SECTION DENOTES SIXTH INGREDIENT:										
SECTION DENOTES SEVENTH INGREDIENT:										
SECTION DENOTES EIGHTH INGREDIENT:										

4.2.2 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD2

Table 6 – Post Adjudication History Compound Detail Record2

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
PRMP only accepts Compound Detail Record1. *DO NOT SEND Compound Detail Record2.*										
SECTION DENOTES NINTH INGREDIENT:										
SECTION DENOTES TENTH INGREDIENT:										
SECTION DENOTES ELEVENTH INGREDIENT:										
SECTION DENOTES TWELVTH INGREDIENT:										
SECTION DENOTES THIRTEENTH INGREDIENT:										
SECTION DENOTES FOURTEENTH INGREDIENT:										
SECTION DENOTES FIFTEENTH INGREDIENT:										

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization D – First DataBank Therapeutic Class code, Generic F – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICO) Assigned Code U – Universal System of Classification Code Z – Mutually Agreed Upon Code							

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4.3 POST ADJUDICATION HISTORY TRAILER RECORD

Table 7 – Post Adjudication History Trailer Record

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	PT – Post Adjudication History Trailer Record	M	P	A	2	1	2	
9Ø1-Ø9	TOTAL RECORD COUNT	Total number of records being submitted, including header and trailer.		M	P	N	1Ø	3	12	
895	TOTAL NET AMOUNT DUE	Summarization of Net Amount Due (281).		M	P	D	12	13	24	
893	TOTAL GROSS AMOUNT DUE	Total sum of the gross amount due fields on the claim level		S	P	D	12	25	36	
894	TOTAL PATIENT PAY AMOUNT	Total sum of the patient pay amount fields on the claim level		M	P	D	12	37	48	
	FILLER			NU		A	3652	49	37ØØ	

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Appendix A: Discussion of MAO COB/TPL Reporting When:

MAO Only Paid

Table 8 – MAO Only Paid

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT		The amount submitted by the COB carrier.	If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT). If the MAO does not store the COB Carrier Amount, the field does not need to be completed
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. If the MAO paid the drug in full, report '1'
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
232	COB PRIMARY PAYER ID	Primary Payer ID associated with the Primary Payer.	Use one of the following Primary Payor IDs when submitting encounter claims to the PRMMIS for Platino Members: **MAOSNP** If the MAO pays for a drug, Field #232 must indicate Primary Payer ID MAOSNP	Field #232 (COB PRIMARY PAYER ID) is REQUIRED. If the MAO paid the drug in full, report MAOSNP.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			MAOSNP represents that the MAO paid for the drug/product. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID'. MEDICAID represents that Puerto Rico Medicaid paid for the drug. The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product **COMMERCIAL** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug before the MAO can consider payment of the drug/product, report 'COMMERCIAL' as the Primary Payer ID in Field #232. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim before the MAO can consider paying for the drug, Field #232 must indicate Primary Payer ID 'TRICARE'."	
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the payment associated to the primary payer reported in Field #232

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
				(COB PRIMARY PAYER ID). If the MAOSNP paid the drug in full, report the MAO paid amount
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service		Field #231 is situational. If the MAO paid the drug in full and the MAO cost sharing is negated ($Ø) or replaced by a nominal copay for a generic ($1) or brand name drug ($2), do not report.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service		Field #229 is situational. If the MAO paid the drug in full and the MAO cost sharing is negated ($Ø) or replaced by a nominal copay for a generic ($1) or brand name drug ($2), do not report
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service		Field #23Ø is situational. If the MAO paid the drug in full and the MAO cost sharing is negated ($Ø) or replaced by a nominal copay for a generic ($1) or brand name drug ($2) and the Platino member was charged a copayment, enter the nominal copay amount.
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	**MAOSNP** If the MAO pays for a drug as a secondary payer to a Commercial insurance plan or TRICARE, Field #238 must indicate Secondary Payer ID 'MAOSNP.' MAOSNP represents that the MAO paid for the drug. **MEDIGAP** If the Platino Member has a 'Medicare gap' insurance as a commercial insurance plan that covers Medicare or MAO cost sharing.	Field #238 (COB SECONDARY PAYER ID) is situational. If the MAO paid the drug in full as the primary payer, do not report.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Medicare gap insurance is always secondary to Medicare or an MAO. MEDIGAP represents an insurance plan that covers only Medicare/MAO cost sharing. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #338 must indicate Secondary Payer ID 'MEDICAID'. MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product. The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Secondary Payer ID standpoint may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug/product, report 'COMMERCIAL' as the Secondary Payer ID in Field #338. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #338 must indicate Secondary Payer ID 'TRICARE'.	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is situational. If the MAO paid the drug in full as the primary payer, do not report.
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is situational. If the MAO paid the drug in full as the primary payer, do not report.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is situational. If the MAO paid the drug in full as the primary payer, do not report.
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is situational. If the MAO paid the drug in full as the primary payer, do not report.
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	Ø0 – Not Specified by patient Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other Coverage Billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.	Field #3Ø8-C8 is REQUIRED. If the MAO paid the drug in full, report Ø1.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan. 192Ø = Medicaid 193Ø = Medicare	193Ø – MEDICARE – The federal program providing health insurance for people aged 65 and older and for disabled people of all ages.	Field #6Ø1-Ø1 is REQUIRED. If only MAO funding is used to pay the drug/product report 193Ø (MEDICARE). If the drug is a wraparound paid drug (Puerto Rico Medicaid funds are used to pay the drug/product), claim report 192Ø (Medicaid).
393-MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MV).	**393-MV BENEFIT STAGE QUALIFIER** Code qualifying the 'Benefit Stage Amount' (394-MV). Blank – Not Specified Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage limit and until the total out of pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø – Not paid under Part D, paid under Part C benefit (for MA-PD plan). • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5	Field #393 is situational. Use the applicable MV Benefit Stage Qualifier in Column D.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage. 6Ø – Not paid under Part D, paid as or under a supplemental benefit only • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit) • The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. • When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified, either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18 **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug.	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			51 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. • When the qualifier value of 51 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid and 566-J5 Other Payer Amount Recognized) of the claim. 62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only. • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. nonformulary, quantity limit, etc.),	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			• When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights " 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: • When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer Ø5 – Amount of Copay (518-FI) as reported by previous payer Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer 1Ø – Amount Attributed to Provider Network Selection	Field #351-NP is situational Report the applicable value from Column D. If the MAO paid the drug in full, leave blank (Not Specified).

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MAO Paid & Wraparound Picked Up Copay

Table 9 – MAO Paid & Wraparound Picked Up Copay

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.		If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT).
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. The MAO SNP would be considered the primary payer when the Platino Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibles) and Puerto Rico Medicaid would be considered the second payer when no other insurance coverage exists.
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB. M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
232	COB PRIMARY PAYER ID	Primary Payer ID associated with the Primary Payer.		Field #232 (COB PRIMARY PAYER ID) is REQUIRED when both MAO funds and Medicaid funds were used to pay a drug/biological/item. Enter MAOSNP in Field #232 to represent that the MAO is the primary payer

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the payment associated to the primary payer report in Field #232 (COB PRIMARY PAYER ID). The MAO SNP would be considered the primary payer when the Plaidno Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibles).
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		Field #231 is required when the Primary Payer reported in Field #232 assessed deductible. Report the deductible associated to the primary payer reported in Field #232 (COB PRIMARY PAYER ID). If the Primary Payer reported in Field #232 did not assess deductible leave blank.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #229 is required when the Primary Payer reported in Field #232 assessed coinsurance. Report the coinsurance associated with the primary payer reported in Field #232 (COB PRIMARY PAYER ID).
230	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		Field #230 is required when the Primary Payer reported in Field #232 assessed copayment. Report the copayment associated with the primary payer reported in Field #232 (COB PRIMARY PAYER ID).

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
338	COB SECONDARY PAYER ID	ID assigned to secondary payer.		Field #338 (COB SECONDARY PAYER ID) is required when the MAO and another insurance plan or Medicaid paid for the drug or cost sharing. Enter MEDICAID when Medicaid funds were used secondary to the MAO funds to cover any portion of the payment for a drug/biological/item.
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is required when the Secondary Payer paid for the drug/product or the Platino Member's cost sharing (e.g., copayment).
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is required when there is a Secondary Payer deductible that was assessed on the drug/product. Report the deductible amount, if applicable.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is required when there is a Secondary Payer coinsurance that was assessed on the drug/product. Report the coinsurance amount, if applicable.
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is required when there is a Secondary Payer copayment that was assessed on the drug/product. Report the copayment amount if applicable.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other coverage billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection or network selection.	Field #3Ø8-C8 is REQUIRED. Report the appropriate code from Column D that represents other coverage for the drug/product.
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan 192Ø = Medicaid 193Ø = Medicare Blank = Neither	193Ø – MEDICARE – The federal program providing health insurance for people aged 65 and older and for disabled people of all ages.	Field #6Ø1-Ø1 is REQUIRED. If the MAO paid as the primary payer and Medicaid was reported as the secondary payer, enter 193Ø. This field should be completed based on primary payer when more than one funding source is used in payment related to MAO/Medicaid dual eligible coverage (i.e., Platino members).
393-MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	393-MV BENEFIT STAGE QUALIFIER Code qualifying the 'Benefit Stage Amount' (394-MW). Blank – Not Specified	Field #393-MV is REQUIRED. Use the applicable MV Benefit Stage Qualifier in Column D.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage limit and until the total out of pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year 5Ø – Not paid under Part D, paid under Part C benefit (for MA-PD plan): • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage 6Ø – Not paid under Part D; paid as or under a supplemental benefit only • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			benefit is provided (drugs covered outside of the allowable Part D benefit). • The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. • When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur. 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 61 – Part D drug not paid by Part D plan benefit: paid as or under a co-administered insured benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. • When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			566-J5 Other Payer Amount Recognized) of the claim. 62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. nonformulary, quantity limit, etc.) • When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 –	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: • When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer Ø5 – Amount of Copay (518-FI) as reported by previous payer Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer 1Ø – Amount Attributed to Provider Network Selection	Field #351-NP is REQUIRED. Report the applicable value from Column D.

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Wraparound Paid (Medicaid Only)

Table 10 – Wraparound Paid (Medicaid Only)

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier		If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT). If the MAO does not store the COB Carrier Amount, the field does not need to be completed.
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. If Medicaid Wraparound paid the drug in full, report '1'
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB. M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the payment associated to the primary payer report in Field #232 (COB PRIMARY PAYER ID). If the Medicaid Wraparound paid the drug in full, report the MAO paid amount.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		Field #231 is situational. If Medicaid Wraparound paid the drug, deductible is not applicable. Do not report.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #229 is situational. If Medicaid Wraparound paid the drug, coinsurance is not applicable. Do not report.
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service		Field #23Ø is situational. If Medicaid Wraparound paid the drug and a copayment is applied, report the copayment amount. If no copayment was applied, do not report.
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	**MAOSNP** If the MAO pays for a drug as a secondary payer to a Commercial insurance plan or TRICARE, Field #238 must indicate Secondary Payer ID 'MAOSNP'. MAOSNP represents that the MAO paid for the drug. **MEDIGAP** If the Platino Member has a 'Medicare gap' insurance as a commercial insurance plan that covers Medicare or MAO cost sharing. Medicare gap insurance is always secondary to Medicare or an MAO. MEDIGAP represents an insurance plan that covers only Medicare/MAO cost sharing. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID.' MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product.	Field #238 (COB SECONDARY PAYER ID) is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug/product, report 'COMMERCIAL' as the Secondary Payer ID in Field #338. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #338 must indicate Secondary Payer ID 'TRICARE.'	
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is situational. If the Medicaid Wraparound paid the drug in full as the primary payer, do not report.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient. Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other Coverage Billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists-payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.	Field #3Ø8-C8 is REQUIRED. If Medicaid Wraparound paid the drug in full, report Ø1.
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan: 192Ø = Medicaid 193Ø = Medicare Blank = Neither	192Ø – MEDICAID – A program, financed jointly by the federal government and the states, that provides health coverage for mostly low-income women and children as well as nursing home care for low-income elderly.	Field #6Ø1-Ø1is required. If the drug is a Medicaid Wraparound paid drug (Puerto Rico Medicaid funds are used to pay the drug/product), then report 192Ø (Medicaid).
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	393-MV BENEFIT STAGE QUALIFIER Code qualifying the 'Benefit Stage Amount' (394-MW) Blank – Not Specified Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.	Field #393-MV is situational. If Medicaid Wraparound paid the drug in full, do not report.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan): • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 5Ø6-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage. 6Ø – Not paid under Part D; paid as or under a supplemental benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit).	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			• The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. • When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 568-J5 Other Payer Amount Recognized) of the claim. • Since 60 is not specific to a Part D covered drug versus a non-Part D drug/non-qualified, either of the following situations may occur 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value 018 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs, Benefit Stage Qualifier 60 will be returned without the Approved Message Code value of 018 **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug 61 – Part D drug not paid by Part D plan benefit, paid as or under a co-administered insured benefit only • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit, but is paid under the co-administered insured benefit. • When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 568-J5 Other Payer Amount Recognized) of the claim	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only. • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit, but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing. • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g., nonformulary, quantity limit, etc.) • When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare;	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			paid by the beneficiary under plan-sponsored negotiated pricing • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer.	Field #351-NP is situational. Report the applicable value from Column D. If Medicaid Wraparound paid the drug in full, leave blank.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection.	

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Commercial Insurance as Primary and MAO as Secondary

Table 11 – Commercial Insurance as Primary and MAO as Secondary

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.		If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT)
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. When a Commercial Health Insurance Plan is a primary payer to Medicare Advantage, report '1'.
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB. M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
232	COB PRIMARY PAYER ID	Primary Payer ID associated with the Primary Payer.	**MAOSNP** If the MAO pays for a drug, Field #232 must indicate Primary Payer ID MAOSNP. MAOSNP represents that the MAO paid for the drug/product **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID.' MEDICAID represents that Puerto Rico Medicaid paid for the drug.	Field #232 (COB PRIMARY PAYER ID) is REQUIRED. If a Commercial Health Insurance Plan is primary to Medicare Advantage, report 'COMMERCIAL'.

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug before the MAO can consider payment of the drug/product, report 'COMMERCIAL' as the Primary Payer ID in Field #232. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim before the MAO can consider paying for the drug, Field #232 must indicate Primary Payer ID 'TRICARE'.	
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the Commercial Health Insurance Plan payment.
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.	ADMINISTRACION DE SEGUROS DE SALUD 23 - 000456	Field #231 is required when the Primary Payer reported in Field #232 assessed deductible. Report the deductible associated to the Commercial Health Insurance Plan reported in Field #232

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
				(COB PRIMARY PAYER ID) If the Commercial Health Insurance Plan did not assess deductible, do not report.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #229 is required when the Primary Payer reported in Field #232 assessed coinsurance. Report the coinsurance associated with the Commercial Health Insurance Plan reported in Field #232 (COB PRIMARY PAYER ID). If the Commercial Health Insurance Plan did not assess coinsurance, do not report.
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		Field #23Ø is required when the Primary Payer reported in Field #232 assessed a copayment. Report the copayment associated with the Commercial Health Insurance Plan reported in Field #232 (COB PRIMARY PAYER ID). If the Commercial Health Insurance Plan did not assess a copayment, do not report.
238	COB SECONDARY PAYER ID ADMINISTRACION DE SEGUROS DE SALUD 23 - 00456	ID assigned to secondary payer.	**MAOSNP** If the MAO pays for a drug as a secondary payer to a Commercial insurance plan or TRICARE, Field #238 must indicate Secondary Payer ID 'MAOSNP.' MAOSNP represents that the MAO paid for the drug. **MEDIGAP** If the Platino Member has a 'Medicare gap' insurance as a commercial insurance plan that covers Medicare or MAO cost sharing.	Field #238 is required when the MAO is the secondary payer to a Commercial Health Insurance Plan to report payment of Commercial Health Insurance deductible, coinsurance, and/or copayment. If Medicare Advantage paid any portion of the Commercial Health Insurance cost sharing, then

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			Medicare gap insurance is always secondary to Medicare or an MAO MEDIGAP represents an insurance plan that covers only Medicare/MAO cost sharing. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID.' MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product. The only time MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product **COMMERCIAL** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug/product, report 'COMMERCIAL' as the Secondary Payer ID in Field #238. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #238 must indicate Secondary Payer ID 'TRICARE.'	report the secondary payer ID as 'MAOSNP.'

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is required when the Secondary Payer paid any portion of the drug or Commercial Health Insurance Plan cost sharing (i.e., deductible, coinsurance, and/or copayment). Report the amount that Medicare Advantage paid.
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is required when there is a Secondary Payer deductible that was assessed on the drug/product. When Medicare Advantage pays secondary to a primary Commercial Health Plan where no deductible is assessed, leave blank.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is required when there is a Secondary Payer coinsurance that was assessed on the drug/product. When Medicare Advantage pays secondary to a primary Commercial Health Plan where no coinsurance is assessed, leave blank.
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is required when there is a Secondary Payer copayment that was assessed on the drug/product. When Medicare Advantage pays secondary to a primary Commercial Health Plan where no copayment is assessed, leave blank.

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient. Ø1- No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other coverage billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.	Field #3Ø8-C8 is REQUIRED. Report the appropriate code from Column D that represents other coverage for the drug/product. When Medicare Advantage is secondary to a primary Commercial Health Insurance, report Ø2 when reporting the Commercial Health Insurance Plan as the primary payer.
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan: 192Ø = Medicaid 193Ø = Medicare Blank = Neither	Four spaces	Field #6Ø1-Ø1 is REQUIRED. When Medicare Advantage is a secondary payer to a primary Commercial Health Insurance Plan, report 193Ø (MEDICARE).
393-MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	393-MV BENEFIT STAGE QUALIFIER Blank – Not Specified Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage	Field #393-MV is REQUIRED. Use the applicable MV Benefit Stage Qualifier in Column D. When Medicare Advantage is responsible to pay Commercial Health Insurance cost sharing only as a secondary payer, report 'F9' (F9 Total Amount Paid, and 568-J5 Other Payer Amount Recognized) of the claim.

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan): • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage. 6Ø – Not paid under Part D; paid as or under a supplemental benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit). • The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.	

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			• When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug 61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. • When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g., nonformulary, quantity limit, etc.). • When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights."	

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan. • When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Code qualifying the 'Benefit Stage Amount' (394-MW).	

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer. Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer. Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection.	Field #351-NP is REQUIRED When Medicare Advantage is a secondary payer to a Commercial Health Insurance Plan and only responsible to pay Commercial Health Insurance cost sharing only as a secondary payer, report Ø6.

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Appendix B: Change Summary

Version	Issue Date	Modified By	Comments/Reason
1.0	02/16/2017	Wil Joslyn	Original document with formatting updates.
2.0	06/30/2017	Wil Joslyn	Page 159: Added the following text to the 897 – TRANSACTION ID CROSS REFERENCE field (PRMP Requirement column): "The 18-digit transaction ID of the NCPDP encounter that is being voided by this reversal is entered here." Page 162. Updated the 896 – TRANSACTION ID field (PRMP Requirement column) with "Every claim in the file must contain the unique 18-digit Transaction ID assigned by MC-21 during adjudication." Page 193: Removed "ORIGINAL TRANSACTION ID" and "VOIDED TRANSACTION IDENTIFIER" rows Changed the following FILLER row values to: Length to 423. Start position from 3314 to 3296.
3.0	12/15/2019	Wil Joslyn	Update for "Other Payer" reporting for MAOs and general clean up.
		Page 1	Text added to Section 1 Introduction.
		Page 3	Text added to Section 2 NCPDP Post Adjudication Transaction Standard Version 4.2 File Information
		Page 4	Text added to Section 2.3 Additional NCPDP Post Adjudication Transaction Standard Version 4.2 File Information.
		Page 4	Transaction Specific Information Column header "Mandatory or Situational" changed to "Usage" and new usage type added "NU" for "Fields Not Used" by PRMMIS. All fields that are used by PRMMIS during processing are identified as "Required". Column header "PRDOH Requirement" changed to "PRMP Comment."
		Page 7	Header Record Field 879 "Sending entity identifier" value changed to "PRMP assigned six-digit trading partner ID."
		Page 8	Field 880-K7 – "Receiver ID" value changed to "PRMMIS."
		Page 9	Detail Record starts.

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Version	Issue Date	Modified By	Comments/Reason
		Page 10	Field 3Ø2-C2 comment changed to "PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number."
		Page 10	Field 716-SY comment changed to "Required when available in the payer's adjudication system."
		Page 10	Field 717-SX comment changed to "Required when available in the payer's adjudication system."
		Page 11	Field 729-TA is not used by PRMMIS.
		Page 11	Field 214 is not used by PRMMIS.
		Page 11	Field 721-MD comment changed to "Required when available in the payer's adjudication system.
		Page 11	Field 274 is not used by PRMMIS
		Page 11	Field 288 is not used by PRMMIS.
		Page 11	Field 331-CX has only one valid value (Ø6).
		Page 11	Field 332-CY comment changed to "PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number."
		Page 12	Field 716-SY is not used by PRMMIS.
		Page 12	Field 717-SX is not used by PRMMIS.
		Page 12	Field 729-TA is not used by PRMMIS.
		Page 12	Field 3Ø4-C4 comment changed to "Required when available in the payer's adjudication system."
		Page 12	Field 3Ø5-C5 is not used by PRMMIS.
		Page 12	Field 247 is not used by PRMMIS.
		Page 12	Field 2Ø8 is not used by PRMMIS.
		Page 13	Field 3Ø3-C3 is not used by PRMMIS
		Page 13	Field 3Ø6-C6 is not used by PRMMIS.
		Page 13	Field 3Ø9-C9 is not used by PRMMIS.
		Page 13	Field 215 Comment changed to "PRMP assigned trading partner ID of MCO/MAO."

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Version	Issue Date	Modified By	Comments/Reason
		Page 13	Field 212 is not used by PRMMIS.
		Page 13	Field 279 is not used by PRMMIS.
		Page 14	Field 282 is not used by PRMMIS – all three.
		Page 14	Field 292 is not used by PRMMIS.
		Page 14	Field 3Ø8-C8 Comment changed to "If available, report the appropriate value that represents other coverage for the drug/product."
		Page 16	Field 6Ø1-Ø1 added value "If neither MAO nor Wraparound is the primary payer, enter four spaces" and Comment changed to "Use 193Ø (Medicare) when only MAO funding is used to pay the drug/product. Use 192Ø (Medicaid) when only Puerto Rico Medicaid funds are used to pay the drug/product. If neither, enter spaces."
		Page 17	Field 2Ø2-B2 Value shortened to "Ø1 – National Provider Identifier (NPI), Ø5 – Medicaid ID if atypical" and Comment shortened to "Required."
		Page 17	Field 2Ø1-B1 Comment shortened to "Required."
		Page 17	Field 2Ø2-B2 is not used by PRMMIS.
		Page 17	Field 2Ø1-B1 is not used by PRMMIS.
		Page 17	Field 727-SS is not used by PRMMIS.
		Page 18	Field 732 is not used by PRMMIS.
		Page 19	Field 81Ø-8A is not used by PRMMIS.
		Page 18	Field 15Ø is not used by PRMMIS
		Page 18	Field 266 is not used by PRMMIS
		Page 18	Field 466-EZ is not used by PRMMIS
		Page 19	Field 411-DB is not used by PRMMIS.
		Page 19	Field 296 comment changed to "Required when available in the payer's adjudication system."
		Page 19	Field 295 is not used by PRMMIS.
		Page 19	Field 716-SY is required by PRMMIS.
		Page 19	Field 717-SX is required by PRMMIS.
		Page 19	Field 81Ø-8A is required by PRMMIS.

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Version	Issue Date	Modified By	Comments/Reason
		Page 22	Field 436-E1 has only one valid value.
		Page 23	Field 239 is not used by PRMMIS
		Page 23	Field 3Ø7-C7 is not used by PRMMIS.
		Page 23	Field 384-4X is not used by PRMMIS.
		Page 23	Field 419-DJ is not used by PRMMIS.
		Page 23	Field 278 is not used by PRMMIS.
		Page 23	Field 217 is not used by PRMMIS.
		Page 24	Field 268 is not used by PRMMIS
		Page 24	Field 1Ø2-A2 is not used by PRMMIS.
		Page 24	Field 216 is not used by PRMMIS.
		Page 26	Field 429-DT is not used by PRMMIS.
		Page 26	Field 6ØØ-28 is not used by PRMMIS.
		Page 27	Field 254 is not used by PRMMIS.
		Page 27	Field 996-G1 is not used by PRMMIS.
		Page 28	Field 492-WE PRMMIS will only use one Diagnosis Code.
		Page 28	Field 424-DO PRMMIS will only use one diagnosis Code.
		Pages 29 – 36	All 439-E4, 44Ø-E5, 441-E6, & 474-8E fields are not used by PRMMIS.
		Page 35	All 511-FB fields are not used by PRMMIS.
		Page 35 – 72	Fields 435-DZ, 434-DY, 532-FW, 397, & 261 are not used by PRMMIS.
		Page 36	Field 146 is not used by PRMMIS.
		Page 36	Field 297 is not used by PRMMIS.
		Page 37	Only one field, 42Ø-DK, is used by PRMMI S
		Page 38 – 73	Fields 6Ø1-24, 243, & 425-DP are not used by PRMMIS.
		Page 36 – 74	Fields 273, 244, & 252 are not used by PRMMIS.
		Page 37 – 79	All occurrences of fields 6Ø1-19 & 6Ø1-16 are not used by PRMMIS.
		Page 38 – 85	All 6Ø1-26 & 6Ø1-25 fields are not used by PRMMIS.
		Page 38 – 91	Fields 257, 221, 869, 256, & 255 are not used by PRMMIS

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Version	Issue Date	Modified By	Comments/Reason
		Page 40 – 91	Fields 572-4U, 519-FJ, 517-FH, 571-NZ, 133-UJ, 134-UK, 135-UM, 136-UN, 137-UP, 272, 223, 26Ø, 284, 2Ø9, 21Ø, 211, & 253 are not used by PRMMIS
		Page 43	Field 561-AZ is not used by PRMMIS.
		Page 45	Field 566-J5 is not used by PRMMIS.
		Page 47 – 91	Fields 522-FM, 348-HH, 347-HJ, 348-HK, 349-HM, 573-4V, 557-AV, 276, 275, 2Ø7, 461-EU, 462-EV, & 299 are not used by PRMMIS.
		Page 51	Field 225 has a new comment, "If available in payer's system."
		Page 52	Field 226 has a new comment, "If the MAO has COB Carrier Amount available."
		Page 53	Field 232 has new possible values.
		Page 54	Field 228 has a new comment, "Required – report the payment associated to the primary payer. The MAO SNP would be considered the primary payer when the Platino Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibility)."
		Page 54	Field 238 has new possible values and a new comment, "Required when the MAO and another insurance plan or Medicaid paid for the drug or cost sharing."
		Page 56	Field 234 has a new comment, "Required when the Secondary Payer paid for the drug/product or the Platino Member's cost sharing."
		Page 56	Field 237 has a new comment, "Required when there is a Secondary Payer deductible that was assessed on the drug/product."
		Page 56	Field 235 has a new comment, "Required when there is a Secondary Payer coinsurance that was assessed on the drug/product."
		Page 56	Field 236 has a new comment, "Required when there is a Secondary Payer copayment that was assessed on the drug/product."
		Page 58	Field 997-G2 is not used by PRMMIS.
		Page 58 – 59	Only the first pair of fields 393-MV & 394MW are used by PRMMIS.
		Page 60	Field 3Ø2-C2 is not used by PRMMIS.
		Page 60	Field 475-J9 is not used by PRMMIS.

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Version	Issue Date	Modified By	Comments/Reason
		Page 62	Field 351-NP has a new comment, "Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim."
		Page 67	Field A37 is not used by PRMMIS.
		Page 68	Field A73 is not used by PRMMIS.
		Page 68	New note added to end of detail record, "Note: "COB/TPL" Indicates that further directions can be found in Appendix A, Discussion of MAO COB/TPL Reporting When."
		Page 74	Field 25Ø is not used by PRMMIS.
		Page 79	Field 251 is not used by PRMMIS.
		Page 88	Field 475-J9 is not used by PRMMIS.
		Page 90	Fields 476-H6 & 878 are not used by PRMMIS.
		Page 96	New Appendix A added "Discussion of MAO COB/TPL Reporting When"
		DXC Technology	Formatting updated.
		DXC Technology	Appendix "Frequently Asked Questions" deleted
4 Ø	11/19/2Ø2Ø	Gainwell Technologies	Gainwell Rebranding

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