

# Addendum 13

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GOVERNMENT OF PUERTO RICO  
Department of Health  
Medicaid Program

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# 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

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### Companion Guide

Version 4.0 – November 2020

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## Disclosure Statement

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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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23 - 000466

Contrato Número





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SEGUROS DE SALUD

23 - 000464

Contrato Número

## Contents

1	Introduction.....	1
1.1	Scope.....	2
2	NCPDP Post Adjudication Transaction Standard Version 4.2 File Information.....	3
2.1	Record Delimiter.....	3
2.2	Over Punch Sign Requirements.....	3
2.3	Additional NCPDP Post Adjudication Transaction Standard Version 4.2 File Information.....	4
3	Naming Convention Rules for NCPDP V4.2 Post Adjudication File:.....	6
4	Transaction Specific Information.....	7
4.1	POST ADJUDICATION HISTORY HEADER RECORD.....	7
4.2	POST ADJUDICATION HISTORY DETAIL RECORD.....	9
4.2.1	POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD1.....	68
4.2.2	POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD2.....	94
4.3	POST ADJUDICATION HISTORY TRAILER RECORD.....	95
Appendix A:	Discussion of MAO COB/TPL Reporting When:.....	96
	MAO Only Paid.....	96
	MAO Paid & Wraparound Picked Up Copay.....	106
	Wraparound Paid (Medicaid Only).....	115
	Commercial Insurance as Primary and MAO as Secondary.....	124
Appendix B:	Change Summary.....	136

## Tables

Table 1 – Example NCPDP Post Adjudication 4.2 Implementation Guides Table.....	2
Table 2 – Over Punch Sign Requirements.....	3
Table 3 – Post Adjudication History Header Record.....	7
Table 4 – Post Adjudication History Detail Record.....	9
Table 5 – Post Adjudication History Compound Detail Record1.....	68
Table 6 – Post Adjudication History Compound Detail Record2.....	94
Table 7 – Post Adjudication History Trailer Record.....	95
Table 8 – MAO Only Paid.....	96
Table 9 – MAO Paid & Wraparound Picked Up Copay.....	106
Table 10 – Wraparound Paid (Medicaid Only).....	115
Table 11 – Commercial Insurance as Primary and MAO as Secondary.....	124

ADMINISTRACION DE  
SEGUROS DE SALUD

23 - 000464

## 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.ncdp.org](http://www.ncdp.org). The contact information is as follows:

National Council for Prescription Drug Programs  
8240 East Reimosa Drive Scottsdale, AZ 85260  
Phone: (480) 477-1000  
Fax (480) 767-1042

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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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SEGUROS DE SALUD ;

23 - 000466

Contrato Número

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
601-04	RECORD TYPE	Type of record being submitted.	PA – Post Adjudication History Header Record	M	P	A	2	1	2	Required
601-08	TOTAL RECORD COUNT	Total number of records being submitted, including header and trailer.		M	P	N	10	3	12	Required
896	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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SEGUROS DE SALUD ;

23 - 000466

Contrato Número

## 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

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

ADMINISTRACION DB  
 SEGUROS DE SALUD ,

23 - 000469

Contrato Número



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

Decimal points are usually implied, not explicit in the text. Using numbers with two decimal digits: 100000{ 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 NCPDP 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
  - NU – 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

ADMINISTRACION DE  
SEGUROS DE SALUD,  
23 - 000466

Contrato Número

- **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 "1234ABC44bbbb"
  - **N – Unsigned Numeric – always right justified, zero filled and default values of zeros**
    - Example: 9(7)9999 represents "999999999"
  - **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 \$\$\$\$Sec
- **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**



ADMINISTRACION DB  
SEGUROS DE SALUD ,

23 - 0 0 0 4 66

Contrato Número

### 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

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**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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ADMINISTRACION DE  
SEGUROS DE SALUD ,

23 - 0 0 0 4 64

Contrato Número



#### 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 filed directly to a data element pertinent to trading electronically with PRMP.

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##### 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
801-04	RECORD TYPE	Type of record being submitted.	PA – Post Adjudication History Header Record	M	P	A	2	1	2	Required
102-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
378	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
808-5C	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	28	35	Required
										ADMINISTRACION DE SEGUROS DE SALUD 23 - 000469
882-K2	CREATION DATE	Date that the file was created. Not older than 30 days from the actual submission date.	Format CCYYMMDD	M	P	N	8	38	43	Required
882-K3	CREATION TIME	Time that the file was created.	Format HHMM	M	P	N	4	44	47	Required
										Contrato Número

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMSP Requirement
880-K7	RECEIVER ID	An identification number of the endpoint receiver of the data file.	PRMMIS	M	P	A	24	48	71	Required
881-06	REPORTING PERIOD START DATE	The first day of the period being reported in the file.	Format CCYYMMDD	M	P	N	8	72	79	Required
881-05	REPORTING PERIOD END DATE	The last day of the period being reported in the file.	Format CCYYMMDD	M	P	N	8	80	87	Required
702-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
881-JV	TRANSMISSION ACTION	Indicates whether this is a replacement file, file update, or a file delete.	O - Original Submission (New) - a new file	M	P	A	1	89	89	Required
888	SUBMISSION NUMBER	Indicates the number of times that a data set has been retransmitted.	Blank - Not Specified 00 - First Submission 01 - First Resubmission 02 - Second Resubmission 03 - 99 - Number of Resubmission	M	P	A	2	90	91	Required
	FILLER			NUJ	P	A	3609	92	3700	

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ADMINISTRACION DB  
SEGUROS DE SALUD,

23 - 000466

Contrato Número

**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
601-04	RECORD TYPE	Type of record being submitted.	DE – Post Adjudication History Detail Record	M	P	A	2	1	2	Required
398	RECORD INDICATOR	Action to be taken on the record.	0 – New Record	S	P	A	1	3	3	Required
<b>SECTION DENOTES ELIGIBILITY CATEGORY:</b>										
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
698	USER BENEFIT ID	Member's benefit ID based upon User Group Number from Eligibility when submitted by Client.		NU	P	A	10	7	16	
699	USER COVERAGE ID	Member's coverage ID based upon User Group Number submitted by Client on eligibility data.		NU	P	A	10	17	26	
246	ELIGIBILITY GROUP ID	Identifier of the group that determines eligibility parameters for the member when submitted by the client.		NU	P	A	15	27	41	ADMINISTRACION DE SEGUROS DE SALUD 23 - 000469
270	LINE OF BUSINESS CODE	Line of Business Code from Client eligibility or as defined by trading partner agreement.		NU	P	A	6	42	47	Contrato Número
267	INSURANCE CODE	Special group/member data as supplied on eligibility record when supplied by the client.		NU	P	A	20	48	67	

Field	Field Name	Description	Value	Usage	Source	Format	Size	Start	End	PRMP Requirement
220	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	20	88	87	
222	CLIENT PASS THROUGH	Information from Client eligibility when submitted by the client.		N/U	P	A	200	88	287	
<b>SUBSECTION DENOTES CARDHOLDER INFORMATION:</b>										
302-C2	CARDHOLDER ID	Insurance ID assigned to the cardholder or identification number used by the plan.		M	C/P	A	20	288	307	Required PRMITS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number.
710-SY	LAST NAME	Last name.		S	P	A	35	308	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	
280	NAME SUFFIX	Individual name suffix.		N/U	P	A	10	379	386	
720-SR	ADDRESS LINE 1	First line of address information.		N/U	P	A	40	388	428	
727-SS	ADDRESS LINE 2	Second line of address information.		N/U	P	A	40	429	468	
728	CITY	Free-form text for city name.		N/U	P	A	30	469	498	

ADMINISTRACION DE  
SEGUROS DE SALUD,  
23 - 000 4 64



Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
72B-TA	STATE/ PROVINCE ADDRESS	The State/Province Code of the address.		N/A	P	A	2	400	500	
730	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.		N/A	P	A	15	501	515	
830-1W	ENTITY COUNTRY CODE	Code of the country.		N/A	P	A	2	516	517	
214	CAREHOLDER DATE OF BIRTH	Date of Birth of Member.		N/A	P	N	8	518	525	
721-ND	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/A	P	A	1	527	527	
288	PAYROLL CLASS	A field defined by the client indicating the payroll class of the member.		N/A	P	A	1	528	528	
<b>SECTION DEMOTES PATIENT INFORMATION:</b>										
331-CX	PATIENT ID QUALIFIER	Code qualifying the Patient ID (332-CY).	08 - Medicaid ID - A number assigned by a state Medicaid agency	S	P	A	2	529	530	Required
332-CY	PATIENT ID	ID assigned to the patient.	ADMINISTRACION D <sup>S</sup> SEGUROS DE SALUD I  23 - 0 0 0 4 66	S	P	A	20	531	550	Required PRMMS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number.

Contrato Número



POS

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PKIMP Requirement
716-SY	LAST NAME	Last name.		N/U	P	A	35	551	595	
717-SX	FIRST NAME	First name.		N/U	P	A	35	588	620	
718	MIDDLE INITIAL	Middle initial.		N/U	P	A	1	621	621	
280	NAME SUFFIX	Individual name suffix.		N/U	P	A	10	622	631	
726-SR	ADDRESS LINE 1	First line of address information.		N/U	P	A	40	632	671	
727-SS	ADDRESS LINE 2	Second line of address information.		N/U	P	A	40	672	711	
728	CITY	Free-form text for city name.		N/U	P	A	30	712	741	
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.		N/U	P	A	2	742	745	
730	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	760	
304-CA	DATE OF BIRTH	Date of Birth of Member.	Default 00000000	S	P	N	8	761	768	Required when available in the payer's adjudication system
305-C5	PATIENT GENDER CODE	Code identifying the gender of the patient.	Default 0	N/U	P	N	1	769	769	
247	ELIGIBILITY/PATIENT RELATIONSHIP CODE	Individual Relationship Code. Code indicating the relationship between two individuals or entities.	00 - Not Applicable	N/U	P	N	2	770	771	ADMINISTRACION DB SEGUROS DE SALUD
208	AGE	Calculated from Date of Birth (204-C4).	Default 000	N/U	P	N	3	772	774	23 - 000 4 66

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Contrato Número

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRNP Requirement
303-C3	PERSON CODE	Code assigned to a specific person within a family.		NIU	P	A	3	775	777	
308-C8	PATIENT RELATIONSHIP CODE	Code indicating relationship of patient to cardholder.	Ø - Not Specified	NIU	G	N	1	778	778	
308-C9	ELIGIBILITY CLARIFICATION CODE	Code indicating that the pharmacy is clarifying eligibility for a patient.		NIU	G	A	1	779	779	
336-BC	FACILITY ID	ID assigned to the patient's clinic/host party.		NIU	P	A	10	780	789	
<b>SECTION DENOTES BENEFIT CATEGORY:</b>										
301-C1	GROUP ID	ID assigned to the cardholder group or employer group.		NIU	P	A	15	790	804	
215	CARRIER NUMBER	Account Number assigned during installation.		M	P	A	9	805	813	Required PRNP assigned trading partner ID of MCOMAC.
757-U8	BENEFIT ID	Assigned by processor to identify a set of parameters, benefits, or coverage criteria used to adjudicate a claim.		NIU	P	A	15	814	828	
240	CONTRACT NUMBER	Account Number assigned during installation for segments of business.		NIU	P	A	8	829	836	
212	BENEFIT TYPE	Indicates the type of acceptable claims for the group based on the Benefit setup.		NIU	P	A	1	837	837	
278	MEMBER SUBMITTED	A one-position field indicating the type of member submitted claim.		NIU	P	A	1	838	839	

ADMINISTRACION DE  
SEGUROS DE SALUD I

23 - 000464

Contrato Número

POS

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Value	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	840	840	
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 client's copay setup. Processor defined codes.		N/U	P	A	10	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	10	853	853	
308-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	00 - Not Specified by patient 01 - No other coverage - Code used in coordination of benefits transactions to convey that no	S	C	IN	2	863	864	If available, report the appropriate value that represents other coverage for the drug/product.  COB/IPL
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			23 - 000466							

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Contrato Número



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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			<p>other coverage is available.</p> <p>02 - 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.</p> <p>03 - 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.</p> <p>04 - 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.</p>							
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NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			and payment has not been received. 08 - 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.		NUJ	P	A	2	865	866	
801-01	PLAN TYPE	Identifies the type of plan.  <b>ADMINISTRACION DB SEGUROS DE SALUD</b>  <b>23 - 000466</b>	1820 - Medicaid 1830 - Medicare If neither MAC nor Whaparound is the primary payer, enter four spaces.	M	P	A	4	867	870	Use 1830 (Medicare) when only MAC funding is used to pay the drug/product. Use 1820 (Medicaid) when only Puerto Rico Medicaid funds are used to pay the drug/product. If neither, enter spaces.  CORBTP1

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Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
<b>SECTION DENOTES PHARMACY CATEGORY:</b>										
202-B2	SERVICE PROVIDER ID QUALIFIER	Code qualifying the 'Service Provider ID' (201-B1).	01 - National Provider Identifier (NPI) 05 - Medicaid ID if atypical	M	C	A	2	871	872	Required
201-B1	SERVICE PROVIDER ID	ID assigned to a pharmacy or provider.		M	C	A	15	873	887	Required
202-B2	SERVICE PROVIDER ID QUALIFIER (ALTERNATE)	Code qualifying the 'Service Provider ID' (201-B1).		NUJ	P	A	2	888	889	
201-B1	SERVICE PROVIDER ID (ALTERNATE)	ID assigned to a pharmacy or provider.		NUJ	P	A	15	890	904	
886	SERVICE PROVIDER CHAIN CODE	Processor specific ID assigned to a chain by processor.		NUJ	P	A	7	905	911	
853-5P	PHARMACY NAME	Pharmacy name.		M	P	A	70	912	981	Required
726-SR	ADDRESS LINE 1	First line of address information.		M	P	A	40	982	1021	Required
727-SS	ADDRESS LINE 2	Second line of address information.		NUJ	P	A	40	1022	1081	
728	CITY	Free-form text for city name.		M	P	A	30	1082	1081	Required
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.		M	P	A	2	1092	1093	Required
730	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.		M	P	A	15	1094	1108	Required
887	SERVICE PROVIDER COUNTY CODE	Indicates the county of the pharmacy.		NUJ	P	A	3	1109	1111	

ADMINISTRACION DB  
 SEGUROS DE SALUD,  
 23 - 000469

Contrato Número

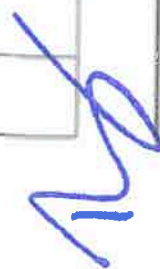
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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
AB3	SERVICE PROVIDER COUNTRY CODE	Indicates the country code of the provider.		NU	P	A	2	1112	1113	
732	TELEPHONE NUMBER	Telephone Number.		NU	P	N	10	1114	1123	
B10-8A	TELEPHONE NUMBER EXTENSION	Extension of the telephone number.		NU	P	N	8	1124	1131	
146	PHARMACY DISPENSER TYPE QUALIFIER	Code qualifying the 'Pharmacy Dispenser Type' (290).		NU	P	A	1	1132	1132	
290	PHARMACY DISPENSER TYPE	Type of pharmacy dispensing product.		NU	P	A	2	1133	1134	
150	PHARMACY CLASS CODE QUALIFIER	Code qualifying the 'Pharmacy Class Code' (289).		NU	P	A	1	1135	1135	
289	PHARMACY CLASS CODE	Indicates class of the pharmacy.		NU	P	A	1	1136	1136	
286	IN NETWORK INDICATOR	Indicates if the pharmacy dispensing the prescription is considered in network.		NU	P	A	1	1137	1137	
S45-2F	NETWORK REIMBURSEMENT ID	Field defined by the processor. It identifies the network, for the covered member, used to calculate the reimbursement to the pharmacy.		NU	P	A	10	1138	1147	ADMINISTRACION DE SEGUROS DE SALUD, 23 - 000464
<b>SECTION DENOTES PRESCRIBER CATEGORY:</b>										
485-EZ	PRESCRIBER ID QUALIFIER	Code qualifying the 'Prescriber ID' (411-DB).	01 - National Provider Identifier (NPI) 05 - Medicaid ID if atypical	M	C	A	2	1148	1149	Required

Contrato Número




Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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	1154	Required
488-EZ	PRESCRIBER ID QUALIFIER (ALTERNATE)	Code qualifying the 'Prescriber ID' (411-DB).		NU	P	A	2	1155	1156	
411-DB	PRESCRIBER ID (ALTERNATE)	ID assigned to the prescriber.		NU	P	A	15	1187	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	1181	Required when available in the payer's adjudication system.
295	PRESCRIBER CERTIFICATION STATUS	Indicates a provider's certification in the health plan program.		NU	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	1228	1253	Required
732	TELEPHONE NUMBER	Telephone Number.		M	P	N	10	1264	1273	Required
810-BA	TELEPHONE NUMBER EXTENSION	Extension of the telephone number.		NU	C/P	N	6	1274	1281	
488-2E	PRIMARY CARE PROVIDER ID QUALIFIER	Code qualifying the 'Primary Care Provider ID' (421-DL).		NU	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.		NU	C/P	A	15	1284	1288	ADMINISTRACION DB SEGUROS DE SALUD ,
716-SY	LAST NAME	Last name.		NU	P	A	35	1289	1333	23 - 000466 Contrato Número

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Value	Usage	Source	Format	Size	Start	End	PRMP Requirement
717-SX	FIRST NAME	First name.		NUJ	P	A	35	1334	1368	
SECTION DENOTES CLAIM CATEGORY:										
399	RECORD STATUS CODE	Identifies the transaction status as assigned by the processor.	<p>1 - Paid - Code indicating that the adjudicated using plan rules and was payable.</p> <p>2 - Rejected - Code indicating that the transaction was denied/rejected.</p> <p>3 - Reversed - Code indicating that the paid transaction was cancelled.</p> <p>4 - Adjusted - Code indicating that the previous transaction was changed.</p> <p>5 - Captured - Code indicating the receipt of the transaction, but no judgment has been made regarding eligibility of the patient or payment.</p> <p>6 - Reverse - Captured - Code indicating that the captured transaction was cancelled.</p>	M	P	A	1	1350	1368	Required
										<p>ADMINISTRACION DE SEGUROS DE SALUD</p> <p>23 - 000469</p> <p>Contrato Número</p>

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
318 	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	ADMINISTRACION DE SEGUROS DE SALUD , 23 - 000 4 6A Contrato Número	M	P	A	2	1371	1372	PRMP requires "Blank" for this data element.

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
455-EM	CLARIFICATION CODE PRESCRIPTION SERVICE REFERENCE NUMBER QUALIFIER	of the payment of the claim. 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 ADMINISTRACION DE SEGUROS DE SALUD 23 - 000469
402-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 Contrato Número
436-E1	PRODUCT SERVICE ID QUALIFIER	Code qualifying the value in 'Product/Service ID' (407-D7).	36 - NDC	M	C	A	2	1386	1387	Required
407-D7	PRODUCT SERVICE ID	ID of the product dispensed or service provided.		M	C	A	18	1388	1406	Required NDC drug code if a compounded drug is being reported; this field should be all zeros.
401-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
579	ADJUDICATION DATE	Date that the claim or adjustment is processed.		M	P	N	8	1415	1422	Required

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
203	ADJUDICATION TIME	Time that the claim or adjustment is processed.		NU	P	N	8	1423	1428	
203	ORIGINAL CLAIM RECEIVED DATE	The date that the pharmacy submitted the claim electronically for a paper claim-matching program.		NU	P	N	8	1423	1436	
210	CLAIM SEQUENCE NUMBER	Indicates the sequence of this claim within the set of claims submitted.		NU	P	N	5	1437	1441	
213	BILLING CYCLE END DATE	Cycle end date.		NU	P	N	8	1442	1449	
238	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.		NU	P	A	2	1450	1451	
307-C7	PLACE OF SERVICE	Code identifying the place where a drug or service is dispensed or administered.		NU	C	N	2	1452	1453	
384-4X	PATIENT RESIDENCE	Code identifying the patient's place of residence.	Ø - Not Specified	NU	C	N	2	1454	1455	
419-DJ	PRESCRIPTION ORIGIN CODE	Code indicating the origin of the prescription.	Ø - Not Known	NU	C	N	1	1456	1456	
270	MEMBER SUBMITTED CLAIM PAYMENT RELEASE DATE	Indicates the date that the member-submitted claim became payable, which could differ from the check date.		NU	P	N	8	1457	1464	ADMINISTRACION DB SEGUROS DE SALUD, 23 - 000469
217	CLAIM DATE RECEIVED IN THE MAIL	Date that the paper claim was received in the mail.		NU	P	N	8	1465	1472	Contrato Número

Puerto Rico Medicaid Program  
 NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
266	INTERNAL MAIL ORDER/ PRESCRIPTION/ SERVICE REFERENCE NUMBER	Field designating the internal prescription number assigned by pharmacies.		NUU	P	A	15	1473	1487	
102-A2	VERSION/ RELEASE NUMBER (OF THE CLAIM)	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.		NUU	C	A	2	1488	1489	
218	CHECK DATE	Member Claims - Actual member check date. Nonmember Claims - Pharmacy check date.		NUU	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.		NUU	P	A	30	1498	1527	
456-EN	ASSOCIATED PRESCRIPTION/ SERVICE REFERENCE NUMBER	Related 'Prescription/Service Reference Number' (452-D2) to which the service is associated.		NUU	C	N	12	1528	1539	ADMINISTRACION DE SEGUROS DE SALUD , 23 - 000469
457-EP	ASSOCIATED PRESCRIPTION/ SERVICE DATE	Date of the 'Associated Prescription/Service Reference Number' (456-EN).		NUU	C	N	8	1540	1547	Contrato Número
442-E7	QUANTITY DISPENSED	Quantity dispensed, expressed in metric decimal units.		M	C	N	10	1548	1557	Required Quantity dispensed - if a compound drug is being reported, this field should be all zeros.

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
403-03	FILL NUMBER	The code indicating whether the prescription is an original or a refill.	00 - Original dispensing - The first dispensing 01 - 99 - Refill number - Number of the replenishment	M	C	N	2	1558	1559	Required Indicates new Rx (zero) or number of refills used.
403-05	DAYS SUPPLY	Estimated number of days that the prescription will last.		M	C	N	3	1560	1562	Required
414-02	DATE PRESCRIPTION WRITTEN	Date that the prescription was written.		M	C	N	8	1563	1570	Required CCYYMMDD
408-08	DISPENSE AS WRITTEN (DAW) PRODUCT SELECTION CODE	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	0 - 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

ADMINISTRACION DE  
SEGUROS DE SALUD,  
23 - 000469

Contrato Número

208

Puerto Rico Medicaid Program  
 NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PHMP Requirement
415-DF	NUMBER OF REFILLS AUTHORIZED	Number of refills authorized by the prescriber.	00 - No refills authorized 01 - 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	
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA - Each GM - Grams ML - Milliliters	M	C	A	2	1575	1576	Required
418-DJ	LEVEL OF SERVICE	Coding indicating the type of services that the provider rendered.	00 - Not Specified 01 - Patient consultation 02 - Home delivery 03 - Emergency service 04 - 24 hour service 05 - Patient consultation regarding generic product selection 06 - In-Home Service	M	C	N	2	1577	1578	Required
								ADMINISTRACION DB SEGUROS DE SALUD, 23 - 000466 Contrato Número		
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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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
344-HF	QUANTITY INTENDED TO BE DISPENSED	shortages do not allow the full quantity 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).		NU	C	N	10	1500	1500	
460-ET	QUANTITY PRESCRIBED	Amount expressed in metric decimal units.		NU	C	N	10	1500	1500	
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
354	FILL NUMBER CALCULATED	Code identifying whether the prescription is an original (00) or by refill number (01 - 99).		NU	P	N	2	1603	1604	Contrato Número
405-EB	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
886-G1	COMPOUND TYPE	Clarifies the type of compound.		NU	C	A	2	1606	1607	
452-EH	COMPOUND ROUTE OF ADMINISTRATION	Code for the route of administration of the complete compound mixture.		NU	C	N	2	1608	1608	

ADMINISTRACION DE  
SEGUROS DE SALUD  
23 - 000469





POS

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
99-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
482-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	00 - Not Specified 01 - International Classification of Diseases (ICD9) 02 - 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
482-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		NIU	C	A	2	1638	1639	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		NIU	C	A	15	1640	1654	
482-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		NIU	C	A	2	1655	1658	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		NIU	C	A	15	1657	1671	
482-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		NIU	C	A	2	1672	1673	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		NIU	C	A	15	1674	1688	Contrato Número
482-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		NIU	C	A	2	1689	1690	

ADMINISTRACION DE  
SEGUROS DE SALUD

23 - 000469

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Puerto Rico Medicaid Program  
 NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
424-DC	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		NUJ	C	A	15	1691	1705	
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.		NUJ	C	A	2	1706	1707	
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		NUJ	C	A	2	1708	1709	
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.		NUJ	C	A	2	1710	1711	
474-BE	DURPPPS 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.		NUJ	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.		NUJ	C	A	2	1714	1715	ADMINISTRACION DE SEGUROS DE SALUD 23 - 000466
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has		NUJ	C	A	2	1716	1717	Contrato Numero

POS

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
441-IE8	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.		NUJ	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.		NUJ	C	N	2	1720	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.		NUJ	C	A	2	1722	1723	
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		NUJ	C	A	2	1724	1725	
441-E8	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.		NUJ	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		NUJ	C	N	2	1728	1729	

ADMINISTRACION DE  
SEGUROS DE SALUD

23 - 00046A

Contrato Número



Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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 pharmacist or the reason for the pharmacist's professional service.		NUJ	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.		NUJ	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.		NUJ	C	A	2	1734	1735	
474-BE	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.		NUJ	C	N	2	1736	1737	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the pharmacist or the reason for the pharmacist's professional service.		NUJ	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.		NUJ	C	A	2	1740	1741	

ADMINISTRACION DE  
SEGUROS DE SALUD  
**23 - 00046G**

Contrato Número

Puerto Rico Medicaid Program  
 NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Value	Usage	Source	Format	Size	Start	End	PRMP Requirement
441-EB	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.		NU	C	A	2	1742	1743	
474-8E	DURPPS 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.		NU	C	N	2	1744	1745	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the pharmacist or the reason for the pharmacist's professional service.		NU	C	A	2	1746	1747	
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		NU	C	A	2	1748	1749	
441-EB	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.		NU	C	A	2	1750	1751	
474-8E	DURPPS 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.		NU	C	N	2	1752	1753	ADMINISTRACION DE SEGUROS DE SALUD

23 - 000469

Contrato Número

APB

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Start	End	PRMP Requirement
438-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.		NU	C	A	1754	1755	
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		NU	C	A	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.		NU	C	A	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.		NU	C	N	1760	1761	
438-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.		NU	C	A	1762	1763	
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		NU	C	A	1764	1765	ADMINISTRACION DE SEGUROS DE SALUD

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23 - 000 4 66

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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.		NU	C	A	2	1786	1787	
474-8E	DURIPPS 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.		NU	C	N	2	1788	1789	
489-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the pharmacist or the reason for the pharmacist's professional service.		NU	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.		NU	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.		NU	C	A	2	1774	1775	
474-8E	DURIPPS 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.		NU	C	N	2	1776	1777	ADMINISTRACION DE SEGUROS DE SALUD
										23 - 000466

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Contrato Número

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PROMP Requirement
475-JB	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		NUJ	C	A	2	1778	1778	
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).		NAU	C	A	18	1780	1788	
878	REJECT OVERRIDE CODE	Indicates the reason for paying a claim when override is used.		NUJ	P	A	1	1799	1799	
511-FB	REJECT CODE	Code indicating the error encountered.		NUJ	C	A	3	1800	1802	
511-FB	REJECT CODE	Code indicating the error encountered.		NUJ	C	A	3	1803	1805	
511-FB	REJECT CODE	Code indicating the error encountered.		NUJ	C	A	3	1808	1808	
511-FB	REJECT CODE	Code indicating the error encountered.		NUJ	C	A	3	1808	1811	
511-FB	REJECT CODE	Code indicating the error encountered.		NUJ	C	A	3	1812	1814	
<b>SECTION DENOTES WORKER'S COMPENSATION CATEGORY:</b>										
435-DZ	CLAIM/REFERENC CE ID	Identifies the claim number assigned by Worker's Compensation Program.		NUJ	C	A	30	1816	1844	
434-DY	DATE OF INJURY	Date on which the injury occurred.		NUJ	C	N	8	1845	1852	
<b>SECTION DENOTES PRODUCT CATEGORY:</b>										
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define		NUJ	P	A	1	1853	1853	

ADMINISTRACION DB  
SEGUROS DE SALUD

23 - 00046A

Contrato Número



ROS

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
387	PRODUCT/ SERVICE NAME	the database used for identifying the product. Product or Service Description or Product Label Name.		NUJ	P	A	30	1854	1883	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.		NUJ	P	A	30	1884	1813	
601-24	PRODUCT STRENGTH	The strength of the product.		NUJ	P	A	15	1814	1828	
243	DOSSAGE FORM CODE	Dosage form code for product identified.		NUJ	P	A	4	1829	1932	
	FILLER			NUJ	P	A	8	1933	1940	
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.		NUJ	P	N	1	1941	1941	
273	MAINTENANCE DRUG INDICATOR	Indicates if the drug is a maintenance drug under the client's benefit plan.		NUJ	P	A	1	1842	1842	
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.		NUJ	P	A	1	1843	1943	
262	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.		NUJ	P	A	1	1844	1844	
287	PRESCRIPTION OVER THE COUNTER INDICATOR	The indicator that specifies this prescription is a federal/legend (Rx prescription only) or non-prescription drug (OTC).		NUJ	P	A	1	1845	1945	Contrato Número

ADMINISTRACION DB  
SEGUROS DE SALUD

23 - 000464

ROS

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMIP Requirement
420-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.	029 - Encounters	M	C	N	2	1946	1947	Required
420-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.		N/U	C	N	2	1948	1949	
420-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.		N/U	C	N	2	1950	1951	
250	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	
601-18	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (601-18) field.		N/U	P	A	1	1953	1953	
601-16	PRODUCT CODE	Code identifying the product being reported.		N/U	P	A	17	1954	1970	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (601-18) field.		N/U	P	A	1	1971	1971	
601-18	PRODUCT CODE	Code identifying the product being reported.		N/U	P	A	17	1972	1988	ADMINISTRACION DE SEGUROS DE SALUD
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (601-18) field.		N/U	P	A	1	1989	1989	23 - 000466
601-18	PRODUCT CODE	Code identifying the product being reported.		N/U	P	A	17	1990	2008	Contrato Número
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.		N/U	P	A	1	2007	2007	

208

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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 inpatient Mail Service only.		N/U	P	N	3	2020	2010	
601-20	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (601-25) field.		N/U	P	A	1	2011	2011	
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2012	2028	
601-28	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (601-25) field.		N/U	P	A	1	2029	2029	
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2030	2040	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (601-25) field.		N/U	P	A	1	2047	2047	
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2048	2054	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (601-25) field.		N/U	P	A	1	2055	2055	
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2056	2082	
SECTION DENOTES FORMULARY CATEGORY:										
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.		N/U	P	A	1	2083	2083	Contrato Número
224	CLIENT FORMULARY FLAG	Indicates that the client has a formulary.		N/U	P	A	1	2084	2084	

ADMINISTRACION DE  
SEGUROS DE SALUD

23 - 000466

208

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
888	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter from formulary file as defined by processor.		NUJ	P	A	B	2085	2092	
258	FORMULARY FILE ID	Identifies the formulary ID used during adjudication of the claim.		NUJ	P	A	15	2093	2107	
255	FORMULARY CODE TYPE	Indicates how the Formulary Benefit is set up. As defined by processor.		NUJ	P	A	1	2108	2108	
<b>SECTION DENOTES PRICING CATEGORY:</b>										
508-F6	INGREDIENT COST PAID	Drug ingredient cost paid included in the "Total Amount Paid" (508-F9).		M	C	D	B	2109	2116	Required
507-F7	DISPENSING FEE PAID	Total amount to be paid by the claims processor.		M	C	D	B	2117	2124	Required
894	TOTAL AMOUNT PAID BY HCO or MAG	Total amount of the prescription regardless of party responsible for payment.		M	P	D	B	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.		NUJ	C	D	B	2133	2140	
505-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 deductibles, over		M	C	D	B	2141	2148	Required
										ADMINISTRACION DE SEGUROS DE SALUD
										23 - 000462

*23*

Contrato Número



Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
516-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	2140	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
518-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.		NAU	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.		NAU	C	D	8	2173	2180	
571-MZ	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.		NAU	C	D	8	2181	2188	
133-UU	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.		NAU	C	D	8	2189	2196	

ADMINISTRACION DE  
SEGUROS DE SALUD

23 - 00046A

Contrato Número



Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Value	Usage	Source	Format	Size	Start	End	FRMP 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.		NUJ	C	D	8	2197	2204	
135-LIM	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.		NUJ	C	D	8	2206	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.		NUJ	C	D	8	2213	2220	
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.		NUJ	C	D	8	2221	2228	ADMINISTRACION DE SEGUROS DE SALUD 23 - 000466a Contrato Número
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a Maximum Allowable Cost (MAC) program.		NUJ	P	A	1	2229	2229	

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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	2230	2231	
260	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	2240	
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.		N/U	P	D	9	2241	2248	
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.		N/U	P	D	9	2250	2258	ADMINISTRACION DB SEGUROS DE SALUD  23 - 000466
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.		N/U	P	D	9	2259	2267	Contrato Número
263	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.		N/U	P	D	9	2268	2276	
430- 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 00000000 zero fill, 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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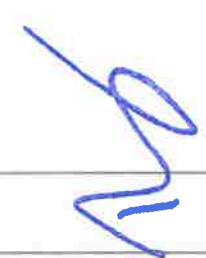
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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRAMP Requirement
409-DB	INGREDIENT COST SUBMITTED	Submitted product component cost of the dispensed prescription. This amount is included in the "Gross Amount Due (432-DU).		\$	C	D	8	2284	2311	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.		\$	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-F8).		\$	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-F8).		NU	C	D	8	2318	2325	
580-AY	PERCENTAGE SALES TAX RATE PAID	Percentage sales tax rate used to calculate "Percentage Sales Tax Amount Paid" (559-AX).		NU	C	D	7	2320	2332	
581-AZ	PERCENTAGE SALES TAX BASIS PAID	Code indicating the percentage sales tax.		NU	C	A	2	2333	2334	
521-FL	INCENTIVE AMOUNT PAID	Amount representing the contractually agreed upon incentive fee paid for specific services rendered. Amount is included in the "Total Amount Paid" (509-F8).		NU	C	D	8	2335	2342	ADMINISTRACION DE SEGUROS DE SALUD 23 - 000466 Contrato Número
562-J1	PROFESSIONAL SERVICE FEE PAID	Amount representing the contractually agreed upon fee for professional services rendered. This amount is included in the		NU	C	D	8	2343	2350	

208

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
564-J3	OTHER AMOUNT PAID QUALIFIER	"Total Amount Paid" (562B-FB). Code clarifying the value in the 'Other Amount Paid' (565-J4).	01 - Delivery Cost 02 - Shipping Cost 03 - Postage 04 - Administrative Cost 05 - Incentive 06 - Cognitive Service 07 - Drug Benefit 08 - Compound Preparation Cost Submitted 09 - Sales Tax 10 - Medication Administration	M	C	A	2	2351	2352	Required
										
565-J4	OTHER AMOUNT PAID	Amount paid for additional costs claimed in 'Other Amount Claimed Submitted' (482-HB).		S	C	D	8	2353	2360	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' (482-HB).		S	C	D	8	2363	2370	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	2380	Required

ADMINISTRACION DE  
SEGUROS DE SALUD  
23 - 000466

Contrato Número

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
586-J5	OTHER PAYER AMOUNT RECOGNIZED	Claimed Submitted (489-H9) Total amount recognized by the processor of any payment from another source.		NU	C	D	8	2381	2388	Not Required COBTPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NO)"	Blank - Not Specified 01 - Amount Applied to Periodic Deductible (\$17-FH) as reported by previous payer. 02 - Amount Attributed to Product Selection/Brand Drug (134-LJK) as reported by previous payer. 03 - Amount Attributed to Sales Tax (523-FN) as reported by previous payer. 04 - Amount Exceeding Periodic Benefit Maximum (520-FK) as reported by previous payer. 05 - Amount of Copay (518-FI) as reported by previous payer. 06 - Patient Pay Amount (505-F5) as reported by previous payer.	B	C	A	2	2389	2396	Required COBTPL
										ADMINISTRACION DE SEGUROS DE SALUD 23 - 000466 Contrato Número

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			<p>Q7 - Amount of Coinsurance (572-4U) as reported by previous payer.</p> <p>Q8 - Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer.</p> <p>Q8 - Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer.</p> <p>10 - Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.</p> <p>11 - Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.</p> <p>12 - Amount Attributed to Coverage Gap (137-LP) that was to be collected from the patient due to a coverage gap as</p>							
										<p>ADMINISTRACION DE SEGUROS DE SALUD</p> <p>23 - 00046A</p> <p>Contrato Número</p>

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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-NO	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	2401	2402	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the 'Other Payer-Patient Responsibility Amount (352-NO)'. Same Values as Above.		S	C	A	2	2401	2402	Required COB/TPL
352-NO	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	2403	2412	Required COB/TPL
281	NET AMOUNT DUE	Net amount paid to provider by the payer or net amount due from the client to the payer, determined by tracing 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' (526-FB).		NUJ	C	N	2	2421	2422	ADMINISTRACION DE SEGUROS DE SALUD
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT	Amount in dollars met by the patient/family in a deductible plan.		NUJ	C	D	8	2423	2430	23 - 000464
513-FD	REMAINING DEDUCTIBLE AMOUNT	Amount not met by the patient/family in the deductible plan.		NUJ	C	D	8	2431	2438	Contrato Numero

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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	2448	
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	
285	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	2488	
348- 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	

ADMINISTRACION DB  
SEGUROS DE SALUD

23 - 000464

Contrato Número

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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-AX).		NU	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).		NU	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).		NU	C	A	2	2495	2496	
567-AV	TAX EXEMPT INDICATOR	Code indicating that the payer and/or the patient is exempt from taxes.		NU	C	A	1	2497	2497	
285	PATIENT FORMULARY REBATE AMOUNT	Credit that the patient receives on this claim from the drug manufacturer.		NU	P	D	8	2498	2503	
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.		NU	P	A	1	2506	2506	
275	MEDICARE RECOVERY DISPENSING INDICATOR	Field to indicate if days' supply on prescription was reduced due to plan limits.		NU	P	A	1	2507	2507	
288	PATIENT SPEND DOWN AMOUNT	Claim dollars applied to patient's spend down account (example: Flexible Spending Account).		NU	P	D	8	2508	2515	

ADMINISTRACION DB  
SEGUROS DE SALUD  
23 - 000 4 64

Contrato Número

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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		M/U	P	D	6	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.		M/U	P	D	6	2524	2531	
207	ADMINISTRATIVE FEE EFFECT INDICATOR	Indicates how the transaction should be counted for administrative fee determination.		M/U	P	A	1	2532	2532	
208	ADMINISTRATIVE FEE AMOUNT	Administrative fee charge per claim.		M/U	P	D	4	2533	2536	
288	INVOICED AMOUNT	Amount Invoiced for this transaction. Determined by Processor.		M/U	P	D	11	2537	2547	
	FILLER			M/U	P	A	10	2548	2557	
128-UC	SPENDING ACCOUNT REMAINING	The balance from the patient's spending account after this transaction was applied.		M/U	C	D	6	2558	2565	
128-LID	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' (SOS-F5). This amount is used in HealthCare Reimbursement Account (HRA) benefits only. This		M/U	C	D	6	2566	2573	
										ADMINISTRACION DE SEGUROS DE SALUD 23 - 0 0 0 4 6a

Contrato Número



Field	Field Name	Description	Value	Usage	Source	Format	Size	Start	End	PRMP Requirement
		field is always a negative amount or zero.								
<b>SECTION DENOTES PRIOR AUTHORIZATION CATEGORY:</b>										
481-EU	PRIOR AUTHORIZATION TYPE CODE	Code identifying the 'Prior Authorization Number Submitted' (482-EV) or beneficiary exemption.		NU	C	N	2	2574	2575	
482-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Number submitted by the provider to identify the prior authorization.		NU	C	N	11	2576	2586	
488-PY	PRIOR AUTHORIZATION NUMBER ASSIGNED	Unique number identifying the prior authorization assigned by the processor.		NU	P	N	11	2587	2597	
288	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code identifying the Prior Authorization Number.		NU	P	N	2	2598	2599	
<b>SECTION DENOTES ADJUSTMENT CATEGORY:</b>										
204	ADJUSTMENT REASON CODE	Reason for adjustment.		NU	P	N	3	2600	2602	
205	ADJUSTMENT TYPE	Type of adjustment.		NU	P	A	1	2603	2603	
687	TRANSACTION ID CROSS REFERENCE	For reversals, ID associated with original claim.		M	P	A	30	2604	2633	Required The TCN of the encounter being voided by this reversal is entered here.
<b>SECTION DENOTES COORDINATION OF BENEFITS CATEGORY:</b>										
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.		S	P	D	B	2634	2641	If available in payer's system.

ADMINISTRACION DB  
SEGUROS DE SALUD

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
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	COB/TPL Required when available in the payer's adjudication system. COB/TPL
228	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 MAOMCO has COB Carrier Amount available. COB/TPL

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ADMINISTRACION DE  
SEGUROS DE SALUD  
23-00046A

Contrato Número

**Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide**

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRNP Requirement
232	COB PRIMARY PAYER ID	ID assigned to primary payer.	<p>out of a retail pharmacy.</p> <p>MAOSNP = When MAO pays for a drug.</p> <p>MEDICAID = When PR Medicaid funding is used to pay for the drug.</p> <p>MEDB = Medicare Part B (in the event that Part D does not cover).</p> <p>MEDD = Medicare Part D.</p> <p>MEDGAP = An insurance plan that covers only Medicare/MAO cost sharing.</p> <p>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.</p> <p>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.</p>	M	C/P	A	10	2644	2653	Required COB/TPL
									<p>ADMINISTRACION DE SEGUROS DE SALUD</p> <p>23 - 00046A</p> <p>Contrato Número</p>	

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Value	Usage	Source	Format	Size	Start	End	PRMP Requirement
228	FILLER COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		NAU S	P C/P	A D	8 8	2654 2662	2661 2669	Required - report the payment associated to the primary payer. The MAO SNP would be considered the primary payer when the Planing 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
			ADMINISTRACION DE SEGUROS DE SALUD							
									23 - 00046a	

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			<p>COMMERCIAL as the Secondary Payer ID in Field #238.</p> <p>TRICARE = When the Platinio Member is a veteran where TRICARE must pay or deny the pharmacy claim.</p>							
	FILLER			NU	P	A	8	2704	2711	
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		S	C/P	D	8	2712	2718	Required when the Secondary Payer paid for the drug/product or the Platinio 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	2720	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
238	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.  COB/TPL

ADMINISTRACION DB  
SEGUROS DE SALUD

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
<b>SECTION DENOTES REFERENCE CATEGORY:</b>										
898	TRANSACTION ID	Internally assigned unique claim ID by the payer.		M	P	A	30	2744	2773	Required Every claim in the file must contain the unique internal Transaction ID (TCN) assigned by PBM during adjudication.
503-F3	AUTHORIZATION NUMBER	Number assigned by the processor to identify an authorized transaction.		N/U	P	A	20	2774	2783	
224	CLIENT SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by client.		N/U	P	A	60	2794	2843	
308	PROCESSOR SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by processor.		N/U	P	A	50	2844	2883	
987-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	
<b>SECTION DENOTES FIELDS ADDED IN VERSIONS CATEGORY:</b>										
383-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (384-MW).	01 - Deductible 02 - Initial Benefit 03 - Coverage Gap (donut hole) 04 - Catastrophic Coverage	M	C	A	2	2895	2896	Required COBTPL
ADMINISTRACION DB SEGUROS DE SALUD										

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23-000466a

Contrato Número



Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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, BQ -- 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-MW).		M	C	D	8	2897	2894	Required COBTPL
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).		NU	C	A	2	2895	2898	
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MW).		NU	C	D	8	2897	2814	
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).		NU	C	A	2	2815	2816	
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MW).		NU	C	D	8	2817	2824	ADMINISTRACION DB SEGUROS DE SALUD 23 - 000466
393-MV	BENEFIT STAGE QUALIFIER	The amount of claim allocated to the Medicare stage identified by the		NU	C	A	2	2825	2826	Contrato Número

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Puerto Rico Medicaid Program  
 NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
384- MW	BENEFIT STAGE AMOUNT	'Benefit Stage Qualifier' (383-MV). The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (383-MV).		N/U	C	D	8	2827	2834	
880- ZG	INVOICED DATE	The date that this claim was included on an invoice.		N/U	P	N	8	2835	2842	
881- 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	2843	2850	
302- C2	CARDHOLDER ID (ALTERNATE)	Insurance ID assigned to the cardholder or identification number used by the plan.		N/U	P	A	20	2851	2870	
882- ZJ	NUMBER OF GENERIC MANUFACTURERS	Number of manufacturers that produce this generic drug provided by drug compendium.		N/U	P	N	3	2871	2873	
475- J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	2874	2875	
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 prescribing pharmacist/professional service).		N/U	C	A	19	2876	2894	
475- J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	2885	2888	

ADMINISTRACION DE  
 SEGUROS DE SALUD  
 23--000464

Contrato Número

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Puerto Rico Medicaid Program  
 NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
478-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).		NU	C	A	19	3097	3015	
475-J8	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (478-H6).		NU	C	A	2	3016	3017	
478-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).		NU	C	A	19	3018	3030	
475-J8	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (478-H6).		NU	C	A	2	3037	3038	
478-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).		NU	C	A	19	3039	3057	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (478-H6).		NU	C	A	2	3058	3059	
478-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).		NU	C	A	19	3060	3078	

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ADMINISTRACION DE SEGUROS DE SALUD

23 - 000469

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide



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' (475-H6).		N/U	C	A	2	3079	3082	
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' (475-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' (475-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

ADMINISTRACION DB  
SEGUROS DE SALUD



23 - 000469

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRNP Requirement
			02 - Amount Attributed to Product Selection/Brand Drug (134-UM) as reported by previous payer. 03 - Amount Attributed to Sales Tax (523-FM) as reported by previous payer. 04 - Amount Exceeding Periodic Benefit Maximum (520-FK) as reported by previous payer. 05 - Amount of Copay (518-F) as reported by previous payer. 06 - Patient Pay Amount (503-F5) as reported by previous payer. 07 - Amount of Coinsurance (572-4U) as reported by previous payer. 08 - Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. 09 - Amount Attributed to Health							COBTPL
										
						ADMINISTRACION DE SEGUROS DE SALUD				
						23 - 0 0 0 4 69				
						Contrato Número				

Puerto Rico Medicaid Program  
 NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			Plan Assistance Amount (129-JD) as reported by previous payer. 10 - Amount Attributed to Provider Network Selection (133-JJ) as reported by previous payer. 11 - Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-LM) as reported by previous payer. 12 - Amount Attributed to Coverage Gap (137-LP) 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.							
									ADMINISTRACION DE SEGUROS DE SALUD, 23 - 000 4 6 A Contrato Número	
352-NO	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	3144	3153	Required
351-NP	OTHER PAYER-PATIENT	Code qualifying the Other Payer-Patient	See 351-NP above for codes.	S	C	A	2	3154	3155	Required COB/TPL

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	RESPONSIBILITY AMOUNT QUALIFIER	Responsibility Amount (352-NQ)¹.								COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	3158	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	3168	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	3188	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	3180	3181	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 AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3202	3203	Required COB/TPL

ADMINISTRACION DB  
SEGUROS DE SALUD



Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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 AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount" (352-NQ).	See 351-NP above for codes. ADMINISTRACION DB SEGUROS DE SALUD.	S	C	A	2	3250	3251	Required COB/TPL

23 - 000466

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	AMOUNT QUALIFIER									
362-NO	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	10	3252	3261	Required
A37	SPECIALTY CLAIM INDICATOR	Indicates whether a claim was filled by a specialty pharmacy or a specialty drug.		NU	P	A	1	3262	3262	COBTPL
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		NU	P	A	3	3263	3265	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		NU	P	A	3	3266	3268	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		NU	P	A	3	3269	3271	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		NU	P	A	3	3272	3274	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		NU	P	A	3	3275	3277	
A38	COPY WAIVER AMOUNT	Dollar amount funded by third party for a copy waiver program where a client funds a portion of their copay amount if they select a certain drug.		NU	P	D	8	3278	3285	

ADMINISTRACION DB  
SEGUROS DE SALUD

23 - 000469

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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	3288	3298	
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	3281	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	3284	3285	
	FILER			N/U	P	A	423	3296	3708	

Note: "COBTPL" indicates that further directions can be found in Appendix A; Discussion of MAO-COBTPL Reporting.

4.2.1 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD1

Table 6 - Post Adjudication History Compound Detail Record1

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
801-04	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

ADMINISTRACION DB  
SEGUROS DE SALUD

23 - 000469

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
462-D2	PRESCRIPTION SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	2 - Service Billing - Transaction is a billing for a professional service performed.	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
<b>SECTION DENOTES FIRST INGREDIENT:</b>										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank - Not Specified 01 - UPC 02 - HRI 03 - NDC 04 - HIBCC 11 - NAPPI 12 - GTIN 15 - GCN 28 - FDB Med Name ID 29 - FDB Routed Med ID 30 - FDB Routed Dosage Form Med ID 31 - FDB Med ID	M	C	A	Z	18	19	Required

ADMINISTRACION DB  
SEGUROS DE SALUD  
23 - 00046A




Puerto Rico Medicaid Program  
 NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format Size	Start	End	PROMP Requirement
			32 - GCN_SEQ_NO 33 - HICL_SEQ_NO 99 - Other						
48B-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	M	C	A	1B	20	38	Required If a compound drug is being reported, this is the NDC of the FIRST component of the compound drug.
44B-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.  ADMINISTRACION DE SEGUROS DE SALUD 23 - 000466a Contrato Número
44B-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 44B-ED).	S	C	D	8	53	50	Required MASK 9(7)9999 zero filled, no sign.
48B-UE	COMPOUND INGREDIENT	Code indicating the method by which the drug cost of an ingredient	\$	C	N	2	61	62	Required



Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format Size	Start	End	PRMIP Requirement
	BASIS OF COST DETERMINATION	used in a compound was calculated.	01 - AMP (Average Wholesale Price) 02 - Local Wholesaler 03 - Direct 04 - EAC (Estimated Acquisition Cost) 05 - Acquisition 06 - MAC (Maximum Allowable Cost) 07 - Usual & Customary 08 - 340B/ Disproportionate Share Pricing/Public Health Service 09 - Other - Different from those implied or specified. 10 - 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						
					ADMINISTRACION DE SEGUROS DE SALUD	23 - 000464			Contrato Numero

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMIP Requirement
221	CLIENT FORMULARY FLAG	Indicates that the client has a formulary.	15 - Free product or no associated cost Blank - Not specified Y - Yes N - No	S	P	A	1	83	83	Indicates that the NDC for the FIRST component of the compound drug is not recognized by PRMIP but the MCO covered the drug.
397	PRODUCT/ SERVICE NAME	Product or Service Description or Product Label Name.		NIU	P	A	30	84	83	Value 'Y'
261	GENERIC NAME	Generic names of the product identified in Product/Service Name.		NIU	P	A	30	94	123	
601-24	PRODUCT STRENGTH	The strength of the product.		NIU	P	A	10	124	133	
243	DOSAGE FORM CODE	Dosage form code for product identified.		NIU	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 - Neulium	S	P	N	1	138	138	Required

ADMINISTRACION DE SEGUROS DE SALUD  
23 - 000464  
Contrato Número

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
425-DP	DRUG TYPE	Codes to indicate the type of drug dispensed.	00 - Not specified 1 - Single Source 2 - Authorized Generic (aka 'Branded Generic') 3 - Generic 4 - Over the Counter 5 - Multi-source Brand	S	P	M	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 M - 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	

ADMINISTRACION DE SEGUROS DE SALUD  
23-000464  
Contrato Número

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format Size	Start	End	PRRHP Requirement
252	FEDERAL DEA SCHEDULE	associated with a specific drug category. The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank - Not Specified 1 - Schedule I Substances (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	
									ADMINISTRACION DE SEGUROS DE SALUD 23 - 00046A Contrato Número
250	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 0 - Was Drug Efficacy Study Implementation (DES) - At One Time But No Longer 1 - Drug Efficacy Study Implementation (DES) Drug	S	P	A 1	143	143	
501-1B	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (501-1B) field.	Blank - Not Specified 1 - First DataBank Formulation ID 2 - Medi-Span Product Line	S	P	A 1	144	144	

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Value	Mandatory or Situational	Source	Format Size	Start	End	PRMP Requirement
			Generic Product Identifier 3 - First Databank 4 - Med-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						
									ADMINISTRACION DE SEGUROS DE SALUD 23 - 00046A Contrato Número

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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							
801-18	PRODUCT CODE	Code identifying the product being reported.		S	P	A	17	145	161	
801-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the 'Product Code' (801-18) field.	Blank -- Not Specified 1 -- First DataBank Formulation ID 2 -- Medt-Span Product Line Generic Product Identifier 3 -- First DataBank 4 -- Medt-Span Product Line Drug Descriptor ID 5 -- First DataBank Medication Name Identifier 6 -- First DataBank Routed Medication Identifier 7 -- First DataBank Routed Dosage Form Modification Identifier	S	P	A	1	162	162	
										ADMINISTRACION DE SEGUROS DE SALUD 23 - 00046A Contrato Número

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Comparison Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			B - 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							
										ADMINISTRACION DE SEGUROS DE SALUD
										23 - 00046A
										Contrato Número
501-18	PRODUCT CODE	Code identifying the product being reported.		S	P	A	17	163	179	
501-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the	Blank - Not Specified	S	P	A	1	160	160	

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format Size	Start	End	PRMP Requirement
		Product Code (821-18) 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 Coverage 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						
									ADMINISTRACION DE SEGUROS DE SALUD
									23 - 000469
									Contrato Número

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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							
601-18	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	188	188	
601-26	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 Generic Product Identifier 3 – First DataBank Product Line Drug Descriptor ID	S	P	A	1	189	189	
										ADMINISTRACION DE SEGUROS DE SALUD 23 - 00046A Contrato Número





Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format Size	Start	End	PRMP Requirement
801-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		S	P	A 17	2000	216	
801-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (801-25) field.	Blank - Not Specified 1 - First DataBank Formulation ID 2 - Med-Span Product Line Generic Product Identifier 3 - First DataBank 4 - Med-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	
<p>ADMINISTRACION DE SEGUROS DE SALUD</p> <p>23 - 000466</p> <p>Contrato Número</p>									

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Value	Mandatory or Situational	Source	Format Size	Start	End	PRMP Requirement	
			<p>D – First Databank Therapeutic Class code, Generic</p> <p>E – First Databank Therapeutic Class code, Standard</p> <p>M – Manufacturer (PICO) Assigned Code</p> <p>U – Universal System of Classification Code</p> <p>Z – Mutually Agreed Upon Code</p>							
801-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		S	P	A 17	218	234		
501-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (801-25) field.	<p>Blank – Not Specified</p> <p>1 – First Databank Formulation ID</p> <p>2 – Medi-Span Product Line Generic Product Identifier</p> <p>3 – First Databank</p> <p>4 – Medi-Span Product Line Drug Descriptor ID</p> <p>5 – First Databank Modification Name Identifier</p> <p>6 – First Databank Rounded Modification Identifier</p> <p>7 – First Databank Rounded Dosage</p>	S	P	A 1	235	235		
					<p>ADMINISTRACION DE SEGUROS DE SALUD</p> <p>23 - 00046A</p> <p>Contrato Número</p>					

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Form Medication Identifier B - First DataBank Medication Identifier E - 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 U - Universal System of Classification Code Z - Mutually Agreed Upon Code							
601-25		Code assigned to product being reported.	Blank - Not Specified	\$	P	A	17	236	252	
601-28		Identifies type of data being submitted in the 'Therapeutic Class Code' (601-26) field.	1 - First DataBank Formulation ID 2 - Medi-Span Product Line	\$	P	A	1	253	253	
ADMINISTRACION DB SEGUROS DE SALUD										

23 - 00046a



Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	U - Universal System of Classification Code Z - Mutually Agreed Upon Code	S	P	A	17	254	270	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0 - 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	
						ADMINISTRACION DE SEGUROS DE SALUD 23 - 000466 Contrato Número				

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			<p>Compliance Packaging.</p> <p>6 - Remote Device Unit Doses - Drug is dispensed at the facility, via a remote device, in a unit of use package.</p> <p>7 - Remote Device Multi-dose 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.</p> <p>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).</p>							
										<p>ADMINISTRACION DE SEGUROS DE SALUD.</p> <p>23 - 0 0 0 4 6G</p> <p>Contrato Número</p>

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format Size	Start	End	PRMP Requirement
520-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA - Each GM - Grams ML - Milligrams	S	C	A	272	273	
298	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code identifying the Prior Authorization Number.	00 - Not Specified 01 - Prior Authorization 02 - Medical Certification 03 - EPSDT (Early Periodic Screening Diagnosis Treatment) 04 - Exemption from Copay and/or Coinsurance 05 - Exemption from RX 06 - Family Planning Indicator 07 - TANF (Temporary Assistance for Needy Families) 08 - Payer Defined Exemption	S	P	N	274	275	ADMINISTRACION DB SEGUROS DE SALUD  23 - 0 0 0 4 69  Contrato Número
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	276	276	
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted	Blank - Not Specified 01 - Average Wholesale Price	S	P	A	277	278	

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
		is calculated based on client pricing.	02 - Acquisition Cost (ACD) 03 - Manufacturer Direct Price 04 - Federal Upper Limit (FUL) 05 - Average Generic Price 06 - Usual & Customary 07 - Submitted Ingredient Cost 08 - State MAC 09 - Unit 10 - Usual & Customary or Copay							
475-J9	DUR CO-AGENT ID-QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H9).	Blank - Not Specified 01 - UPC 02 - HRI 03 - NDC 04 - HIBCC 06 - DUR/PPS 07 - CPT4 08 - CPT5 09 - HCPCS 11 - NAPPI 12 - GTIN 14 - GPI 15 - GCN 16 - GFC 17 - DDID	S	C	A	2	279	280	
										ADMINISTRACION DB SEGUROS DE SALUD, 23 - 000469
										Contrato Número

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	Group Requirement
			18 - First DataBank SmartKey 19 - Truven/Micromedex Generic Master (GM) 20 - NCD9 21 - ICD10 23 - NCCI 24 - SNOMED 25 - CPT 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							
										ADMINISTRACION DE SEGUROS DE SALUD, 23 - 000469 Contrato Número

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format Size	Start	End	PRMP Requirement
478-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or the prescribing pharmacist professional service).		S	C	A 18	281	299	
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product, as defined by processor.		S	P	A 1	300	300	
282	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	
							ADMINISTRACION DE SEGUROS DE SALUD 23 - 000469 Contrato Numero		

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Start	End	PRMP Requirement
			reduction in the ingredient cost. Q - Quantity cutback - A reduction in the quantity.						
809	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter, from formulary file as defined by processor.		S	P	A	302	309	
208	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.		S	P	D	310	318	
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.		S	P	D	319	327	
211	AVERAGE WHOLESAL UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.		S	P	D	328	336	
253	FEDERAL UPPER LIMIT PRICE	Federal Upper Limit Unit Price as defined by processor.		S	P	D	337	345	
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.		S	P	D	346	354	
622-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (509-F6).	00 - Not Specified 01 - Ingredient Cost Paid as Submitted 02 - Ingredient Cost Reduced to AWP Pricing	S	C	M	2	356	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or '2' to put in the field

ADMINISTRACION DB  
SEGUROS DE SALUD

23-000469



**Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide**

Field	Field Name	Description	Values	Mandatory or (Situations)	Source	Format	Size	Start	End	PRMP Requirement
			<p>03 - Ingredient Cost Reduced to AWP Less X% Pricing</p> <p>04 - Usual &amp; Customary Paid as Submitted</p> <p>05 - Paid Lower of Ingredient Cost Plus Fees Versus Usual &amp; Customary</p> <p>06 - MAC Pricing Ingredient Cost Paid</p> <p>07 - MAC Pricing Ingredient Cost Reduced to MAC</p> <p>08 - Contract Pricing</p> <p>09 - Acquisition Pricing</p> <p>10 - ASP (Average Sales Price)</p> <p>11 - AMP (Average Manufacturer Price)</p> <p>12 - 340B/ Disproportionate Share/Public Health Service Pricing</p> <p>13 - WAC (Wholesale Acquisition Cost)</p> <p>14 - Other Payer-Responsible Amount</p>							<p>file created by the translator.</p> <p>08 = 'C' which is for capitaled</p> <p>01 = 'F' which is for FFS</p> <p>14 = 'T' which is TPL</p> <p>00 = 'Z' which is for Zero billed/Provider did not charge</p>
					ADMINISTRACION DE SEGUROS DE SALUD					
					23 - 000469					

Contrato Número

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ADP

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			16 - Patient Pay Amount 18 - 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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ADMINISTRACION DE  
SEGUROS DE SALUD

23 - 000464

Contrato Número

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

ADMINISTRACION DE  
 SEGUROS DE SALUD

23 - 000464

Contrato Número

### 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
801-04	RECORD TYPE	Type of record being submitted.	PT – Post-Adjudication History Trailer Record	M	P	A	2	1	2	
801-09	TOTAL RECORD COUNT	Total number of records being submitted, including header and trailer.		M	P	N	10	3	12	
885	TOTAL NET AMOUNT DUE	Summation 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	3700	

ADMINISTRACION DE  
SEGUROS DE SALUD

23 - 000464

Contrato Número



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

**MAO Only Paid**

Table 3 – MAO Only Paid

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRIMIS	PRMIS 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 Payer IDs when submitting encounter claims to the PRIMIS for Plan 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.

*POS*

ADMINISTRACION DE  
SEGUROS DE SALUD  
23 - 000466

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRIMIS	PRIMIS Instructions
			<p>MAOSWP represents that the MAO paid for the drug/product.</p> <p><b>MEDICAID</b></p> <p>If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #236 must indicate Secondary Payer ID: 'MEDICAID'.</p> <p>MEDICAID represents that Puerto Rico Medicaid paid for the drug.</p> <p>The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Píladino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product.</p> <p><b>COMMERCIAL</b></p> <p>(This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.)</p> <p>If the Píladino 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.</p> <p>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.</p> <p><b>TRICARE</b></p> <p>(This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.)</p> <p>If the Píladino 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'.</p>	
226	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.	<p><b>ADMINISTRACION DB SEGUROS DE SALUD</b></p>	Field #226 is REQUIRED. Report the payment associated to the primary payer reported in Field #232

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23 - 000464

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRIMIS	PRIMIS Instructions
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 (\$0) or replaced by a nominal copay for a generic (\$1) or brand name drug (\$2), do not report.
239	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #239 is situational. If the MAO paid the drug in full and the MAO cost sharing is negated (\$0) or replaced by a nominal copay for a generic (\$1) or brand name drug (\$2), do not report.
230	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.	<p style="text-align: center;">ADMINISTRACION DE SEGUROS DE SALUD  23 - 00046A  Contrato Número</p>	Field #230 is situational. If the MAO paid the drug in full and the MAO cost sharing is negated (\$0) or replaced by a nominal copay for a generic (\$1) or brand name drug (\$2) and the Flatino member was charged a copayment, enter the nominal copay amount.
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	<p>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.</p> <p>WEDGAP If the Flatino Member has a 'Medicare gap' insurance as a commercial insurance plan that covers Medicare or MAO cost sharing.</p>	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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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.3 Instructions	PRMIS Instructions
		<p>Medicare gap insurance is always secondary to Medicare or an MAO.</p> <p>MEDIGAP represents an insurance plan that covers only Medicare/MAO cost sharing.</p> <p><b>MEDICAID</b></p> <p>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.'</p> <p>MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product.</p> <p>The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Pliano member does not have a Commercial Insurance or TRICARE primary that must be billed for consideration of payment of the drug/product.</p> <p><b>COMMERCIAL</b></p> <p>(This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.)</p> <p>If the Pliano Member has a private health insurance plan that must consider payment of a drug/product, report <b>COMMERCIAL</b> as the Secondary Payer ID in Field #238.</p> <p>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.</p> <p><b>TRICARE</b></p> <p>(This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.)</p> <p>If the Pliano Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #238 must indicate Secondary Payer ID 'TRICARE.'</p>	<p style="text-align: center;"> <b>ADMINISTRACION DE SEGUROS DE SALUD</b>   <b>23 - 000466</b>                       Contrato Número                 </p>	

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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 MAC 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 MAC 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 MAC 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 MAC paid the drug in full as the primary payer, do not report.
308- C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	<p>00 - Not Specified by patient</p> <p>01 - No other coverage - Code used in coordination of benefits transactions to convey that no other coverage is available.</p> <p>02 - 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.</p> <p>03 - 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.</p> <p>04 - 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.</p> <p>08 - 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.</p>	<p>Field #308-C8 is REQUIRED. If the MAC paid the drug in full report 01.</p>

ADMINISTRACION DB  
SEGUROS DE SALUD

23 - 0004 6A

Contrato Número






Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRIMIS	PRIMIS Instructions
601-01	PLAN TYPE	Identifies the type of plan. 1820 = Medicaid 1830 = Medicare	1830 – MEDICARE – The federal program providing health insurance for people aged 65 and older and for disabled people of all ages.	Field #01-01 is REQUIRED. If only MAO funding is used to pay the drug/product, report 1830 (MEDICARE). If the drug is a wraparound paid drug (Puerto Rico Medicaid funds are used to pay the drug/product), then report 1820 (Medicaid).
393-MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the Benefit Stage Amount (394-MV). Blank – Not Specified	<p>393-MV BENEFIT STAGE QUALIFIER</p> <p>Code qualifying the 'Benefit Stage Amount' (394-MV). Blank – Not Specified</p> <p>01 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.</p> <p>02 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation.</p> <p>03 – 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.</p> <p>04 – 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.</p> <p>50 – Not paid under Part D, paid under Part C benefit (for MA-PD plan):</p> <ul style="list-style-type: none"> <li>* This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN.</li> <li>* The claim is NOT paid by the Part D plan benefit.</li> <li>* The claim IS paid for by Part C benefit (MA portion of the MA-PD).</li> <li>* When the qualifier value of 50 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>* The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5</li> </ul>	Field #393 is situational. Use the applicable MV Benefit Stage Qualifier in Column D.

ADMINISTRACION DB  
SEGUROS DE SALUD

23 - 000464

Contrato Número




Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			<p>Patient Pay Amount, 5029-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.</p> <ul style="list-style-type: none"> <li>* A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage.</li> <li>60 – Not paid under Part D; paid as or under a supplemental benefit only:             <ul style="list-style-type: none"> <li>* 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.</li> <li>* 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).</li> <li>* The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.</li> <li>* When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>* The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5025-F5 Patient Pay Amount, 5029-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.</li> <li>* 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:                 <ol style="list-style-type: none"> <li>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 of 16 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights."</li> <li>2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 60 will be returned without the Approved Message Code value of 16.</li> </ol> </li> </ul> </li> </ul> <p>Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.</p>	<p>ADMINISTRACION DE SEGUROS DE SALUD</p> <p>23 - 0 0 0 4 66</p> <p>Contrato Número</p>

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	PRMMS Instructions
		<p><b>61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only.</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit.</li> <li>When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>The field 364-MC Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 558-J5 Other Payer Amount Recognized) of this claim.</li> </ul> <p><b>62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only.</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>The field 364-MC Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 558-J5 Other Payer Amount Recognized) of the claim.</li> </ul> <p><b>70 – Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing:</b></p> <ul style="list-style-type: none"> <li>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.).</li> </ul>	<p><b>PRMMS Instructions</b></p> <p style="text-align: right;">ADMINISTRACION DE SEGUROS DE SALUD . <b>23 - 000466</b>  Contrato Número</p>

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			<ul style="list-style-type: none"> <li>* When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>* 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 566-J5 Other Payer Amount Recognized) of the claim.</li> <li>* 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 (548-8F) must be returned with a value 018 -- "Provide Notice: Medicare Prescription Drug Coverage and Your Rights."</li> <li>80 - 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:             <ul style="list-style-type: none"> <li>* 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).</li> <li>* When the qualifier value of 80 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>* 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 566-J5 Other Payer Amount Recognized) of the claim.</li> </ul> </li> <li>82 - Enhance or OTC drug (PDE value of E10) not applicable to the Part D drug spend, but is covered by the Part D plan:             <ul style="list-style-type: none"> <li>* When the qualifier value of 82 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>* 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 566-J5 Other Payer Amount Recognized) of the claim.</li> </ul> </li> </ul>	<p style="text-align: center;">ADMINISTRACION DB SEGUROS DE SALUD . <b>23 - 000 4 66a</b></p> <p style="text-align: center;">Contrato Número:</p>

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

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-LK) 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 (51Ø-FI) as reported by previous payer Ø6 - Patent 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 (12B-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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ADMINISTRACION DE  
SEGUROS DE SALUD  
23 - 000466

Contrato Número



**MAO Paid & Wraparound Picked Up Copay**

Table 3 - MAO Paid & Wraparound Picked Up Copay

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.1 Valid Values or Guidance for PRMIS	PRMIS 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 Picking 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 1 - 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 Services - 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.	ADMINISTRACION DE SEGUROS DE SALUD	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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Contrato Número

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRIMIS	PRIMIS 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 Planee 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.	ADMINISTRACION DE SEGUROS DE SALUD , 23 - 0 0 0 4 6 4	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).

Contrato Número




Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMIS	PRMIS Instructions
236	COB SECONDARY PAYER ID	ID assigned to secondary payer.		Field #236 (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/biarm.
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 Plan/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.
238	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.	ADMINISTRACION DE SEGUROS DE SALUD 23-000466	Field #238 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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Contrato Número

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide



NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
308-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	<p>00 - Not Specified by patient</p> <p>01 - No other coverage - Code used in combination of benefit transactions to convey that no other coverage is available.</p> <p>02 - Other coverage exists - payment collected - Code used in combination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received.</p> <p>03 - Other coverage billed - claim not covered - Code used in combination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered.</p> <p>04 - Other coverage exists - payment not collected - Code used in combination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment has not been received.</p> <p>08 - Claim is billing for patient financial responsibility only - Copy 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.</p>	<p>Field #308-C8 is REQUIRED. Report the appropriate code from Column D that represents other coverage for the drug/product.</p>
001-01	PLAN TYPE	Identifies the type of plan: 1900 = Medicaid 1901 = Medicare Blank = Neither	<p>1900 - MEDICARE - The federal program providing health insurance for people aged 65 and older and for disabled people of all ages.</p>	<p>Field #001-01 is REQUIRED. If the MAC paid as the primary payer and Medicaid was reported as the secondary payer, enter 1900. This field should be completed based on primary payer when more than one funding source is used in payment related to MA/Medicaid dual eligible coverage (i.e., Flatline members).</p>
393-MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	<p>393-MV BENEFIT STAGE QUALIFIER Code qualifying the 'Benefit Stage Amount' (394-MW). Blank - Not Specified</p>	<p>Field #393-MV is REQUIRED. Use the applicable MV Benefit Stage Qualifier in Column D.</p>

ADMINISTRACION DE  
SEGUROS DE SALUD  
23 - 000469



Contrato Número




Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRIMIS	PRIMIS Instructions
			<p><b>§1 – Deductible</b> – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.</p> <p><b>§2 – Initial Benefit</b> – The first monthly benefit, or the first monthly benefit following any break in participation.</p> <p><b>§3 – Coverage Gap (donut hole)</b> – 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.</p> <p><b>§4 – Catastrophic Coverage</b> – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year.</p> <p><b>§5</b> – Not paid under Part D; paid under Part C benefit (for MA-PD plan):</p> <ul style="list-style-type: none"> <li>• This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN.</li> <li>• The claim is NOT paid by the Part D plan benefit.</li> <li>• The claim IS paid for by Part C benefit (MA portion of the MA-PD).</li> <li>• When the qualifier value of 50 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>• The field 394-44V Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 585-J5 Other Payer Amount Recognized) of the claim.</li> <li>• A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage.</li> </ul> <p><b>§6</b> – Not paid under Part D; paid as or under a supplemental benefit only:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental</li> </ul>	<p style="text-align: right;"> <b>ADMINISTRACION DB SEGUROS DE SALUD</b>   <b>23 - 000 4 6A</b>   <b>Contrato Número</b> </p>
				



NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMS	PRMMS Instructions
			<p>benefit is provided (drugs covered outside of the allowable Part D benefit).</p> <ul style="list-style-type: none"> <li>The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.</li> <li>When the qualifier value of 600 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 508-F9 Total Amount Paid, and 508-J5 Other Payer Amount Recognized) of the claim.</li> <li>Since 600 is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur:             <ol style="list-style-type: none"> <li>For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-8F) must be returned with a value 018 - "Provide Notice: Medicine Prescription Drug Coverage and Your Rights."</li> <li>For non-Part D non-qualified drugs Benefit Stage Qualifier 600 will be returned without the Approved Message Code value of 018.</li> </ol> </li> </ul> <p>Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.</p> <p>61 - Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only:</p> <ul style="list-style-type: none"> <li>This qualifier applies to co-administered plans, where the claim is submitted under the Part D BINUPCN and where one pharmacy response is provided.</li> <li>The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit.</li> <li>When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 508-F9 Total Amount Paid, and</li> </ul>	<p style="text-align: right;">             Contrato Número  <b>23 - 000466</b>            ADMINISTRACION DE            SEGUROS DE SALUD         </p>

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			<p>568-J6 Other Payer Amount Recognized) of the claim.</p> <p>62 - Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only</p> <ul style="list-style-type: none"> <li>This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIMP/CN 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.</li> <li>When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>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-J6 Other Payer Amount Recognized) of the claim.</li> </ul> <p>Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.</p> <p>705 - Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing.</p> <ul style="list-style-type: none"> <li>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.).</li> <li>When the qualifier value of 705 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>The field 394-MY Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 568-J6 Other Payer Amount Recognized) of the claim.</li> <li>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 of 18 -</li> </ul>	<p>ADMINISTRACION DB SEGUROS DE SALUD</p> <p>23 - 0004 6A</p> <p>Contrato Número</p>



NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	PRMMIS Instructions
		<p><b>80 – 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:</b></p> <ul style="list-style-type: none"> <li>• 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).</li> <li>• When the qualifier value of 80 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>• 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 566-J5 Other Payer Amount Recognized) of the claim.</li> </ul> <p><b>90 – 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:</b></p> <ul style="list-style-type: none"> <li>• When the qualifier value of 90 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>• 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 566-J5 Other Payer Amount Recognized) of the claim.</li> </ul>	<p><b>PRMMIS Instructions</b></p> <p>"Provide Notice: Medicare-Prescription Drug Coverage and Your Rights."</p>




ADMINISTRACION DE  
 SEGUROS DE SALUD,  
 23 - 000 4 66

Contrato Número

Puerto Rico Medicaid Program  
 NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PREMIUMS	PREMIUMS Instructions
351- MP	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 01 - Amount Applied to Periodic Deductible (517-FH) as reported by previous payer 02 - Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer 03 - Amount Attributed to Sales Tax (523-FN) as reported by previous payer 04 - Amount Exceeding Periodic Benefit Maximum (528-FK) as reported by previous payer 05 - Amount of Copay (518-FI) as reported by previous payer 06 - Patient Pay Amount (506-F5) as reported by previous payer 07 - Amount of Coinsurance (572-4U) as reported by previous payer 08 - Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-LM) as reported by previous payer 09 - Amount Attributed to Health Plan Assistance Amount (129-LD) as reported by previous payer 10 - Amount Attributed to Provider Network Selection	Field #351-MP is REQUIRED. Report the applicable value from Column D.




ADMINISTRACION DE  
 SEGUROS DE SALUD  
 23 - 000466  
 Contrato Número

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 PRIMIS	PRIMIS 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.	ADMINISTRACION DE SEGUROS DE SALUD 23 - 000466	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.

Contrato Número:




Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.3 Valid Values or Guidance for PRMMS	PRMMS 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.
230	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		Field #230 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.	<p><b>MAOSNP</b> 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.</p> <p><b>MEDIGAP</b> If the Plan/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.</p> <p><b>MEDICAID</b> 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.</p>	<p>Field #238 (COB SECONDARY PAYER ID) is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.</p> <p style="text-align: right;">ADMINISTRACION DE SEGUROS DE SALUD, 23 - 000464 Contrato Número</p>

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			<p>The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Planing member does not have a Commercial Insurance or TRICARE primary that must be billed for consideration of payment of the drug/product.</p> <p><b>COMMERCIAL</b> (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Planing 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.</p> <p><b>TRICARE</b> (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Planing Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #238 must indicate Secondary Payer ID 'TRICARE'.</p>	<p style="text-align: center;">   <b>ADMINISTRACION DE SEGUROS DE SALUD</b>  <b>23 - 000466</b>  <b>Contrato Número</b> </p>
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.

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Comparison Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMIS	PRMIS Instructions
238	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #238 is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.
308- CB	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	<p>00 - Not Specified by patient.</p> <p>01 - No other coverage - Code used in coordination of benefits transactions to convey that no other coverage is available.</p> <p>02 - 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.</p> <p>03 - 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.</p> <p>04 - 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.</p> <p>08 - 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.</p>	Field #308-CB is REQUIRED. If Medicaid Wraparound paid the drug in full, report 01.
B01- 01	PLAN TYPE	Identifies the type of plan: 1820 = Medicaid 1830 = Medicare Blank = Neither	<p>1820 - 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.</p>	Field #B01-01 is required. If the drug is a Medicaid Wraparound paid drug (Puerto Rico Medicaid funds are used to pay the drug/product), then report 1820 (Medicaid).
383- MV	BENEFIT STAGE QUALIFIER	Code qualifying the Benefit Stage Amount (384-MV).	<p>383-MV BENEFIT STAGE QUALIFIER</p> <p>Code qualifying the 'Benefit Stage Amount' (384-MV). Blank - Not Specified</p> <p>01 - Deductible - The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.</p>	Field #383-MV is situational. If Medicaid Wraparound paid the drug in full, do not report.

ADMINISTRACION DE  
SEGUROS DE SALUD  
23 - 000464

Contrato Número:



NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	PRMIS Instructions
		<p><b>NCPDP 4.2 Valid Values or Guidance for PRMIS</b></p> <p>02 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation.</p> <p>03 – Coverage Gap (donut hole) – Commonly referred to as the “donut hole.” Amount paid for Medicare prescription drug coverage, with a PCP or an NCPD, after the initial coverage limit, and until the total out of your pocket paid for covered prescription drugs reaches a certain amount.</p> <p>04 – 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.</p> <p>50 – Not paid under Part D; paid under Part C benefit (for MA-PD plan):</p> <ul style="list-style-type: none"> <li>• This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN.</li> <li>• The claim is NOT paid by the Part D plan benefit.</li> <li>• The claim IS paid for by Part C benefit (MA portion of the MA-PD).</li> <li>• When the qualifier value of 50 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>• The field 3B4-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 508-F9 Total Amount Paid, and 506-J5-Other Payer Amount Recognized) of the claim.</li> <li>• A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage.</li> </ul> <p>60 – Not paid under Part D; paid as or under a supplemental benefit only:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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).</li> </ul>	<p>ADMINISTRACION DE SEGUROS DE SALUD</p> <p>23 - 000466</p> <p>Contrato Número</p>



Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			<ul style="list-style-type: none"> <li>▪ The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.</li> <li>▪ When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>▪ The field 364-MC Benefit Stage Amount should be populated with the total amount (total of 525-F5 Patient Pay Amount, 529-F9 Total Amount Paid, and 568-J5 Other Payer Amount Recognized) of the claim.</li> <li>▪ Since 62 is not specific to a Part D covered drug versus a non-Part D drug/non-qualified, either of the following situations may occur:               <ol style="list-style-type: none"> <li>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.*</li> <li>2. For non-Part D non-qualified drugs, Benefit Stage Qualifier 62 will be returned without the Approved Message Code value of 018.</li> </ol> </li> </ul> <p>Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.</p> <p>61 - Part D drug not paid by Part D plan benefit, paid as or under a co-administered insured benefit only.</p> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ The claim is NOT paid by the Part D plan benefit, but is paid under the co-administered insured benefit.</li> <li>▪ When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>▪ The field 364-MC Benefit Stage Amount should be populated with the total amount (total of 525-F5 Patient Pay Amount, 529-F9 Total Amount Paid, and 568-J5 Other Payer Amount Recognized) of the claim.</li> </ul>	<p style="text-align: center;">ADMINISTRACION DE SEGUROS DE SALUD</p> <p style="text-align: center;">23 - 0 0 0 4 66</p> <p style="text-align: center;">Contrato Número</p>



NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	PRMIS Instructions
		<p><b>62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only:</b></p> <ul style="list-style-type: none"> <li>This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIMPEN 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.</li> <li>When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>The field 384-MC Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 568-15 Other Payer Amount Recognized) of the claim.</li> </ul> <p><b>Note:</b> Non-qualified drugs are defined as not meeting the definition of a Part D drug.</p> <p><b>70 – Part D drug not paid by Part D plan benefit paid by the beneficiary under plan-sponsored negotiated pricing:</b></p> <ul style="list-style-type: none"> <li>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.).</li> <li>When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>The field 384-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 568-15 Other Payer Amount Recognized) of the claim.</li> </ul>	<p><b>60 – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare:</b></p>
			<p>ADMINISTRACION DE SEGUROS DE SALUD</p> <p>23 - 000464</p> <p>Contrato Número</p>
			

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRIMIS	PRIMIS Instructions
			<p>paid by the beneficiary under plan-sponsored negotiated pricing</p> <ul style="list-style-type: none"> <li>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).</li> <li>When the qualifier value of 00 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>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 508-J5 Other Payer Amount Recognized) of the claim.</li> </ul> <p>90 - Enhancers or OTC drug (PDE value of E/C) not applicable to the Part D drug spend, but is covered by the Part D plan:</p> <ul style="list-style-type: none"> <li>When the qualifier value of 90 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>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 508-J5 Other Payer Amount Recognized) of the claim.</li> </ul>	
351-NP	<p>OTHER PAYER- PATIENT RESPONSIBILITY AMOUNT QUALIFIER</p>	<p>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.</p>	<p>Blank - Not Specified</p> <p>01 - Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.</p> <p>02 - Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.</p> <p>03 - Amount Attributed to Sales Tax (523-FN) as reported by previous payer.</p> <p>04 - Amount Exceeding Periodic Benefit Maximum (520-FK) as reported by previous payer.</p> <p>05 - Amount of Copay (518-FI) as reported by previous payer.</p> <p>06 - Patient Pay Amount (505-F5) as reported by previous payer.</p> <p>07 - Amount of Coinsurance (572-4U) as reported by previous payer.</p>	<p>Field 351-NP is situational. Report the applicable value from Column D. If Medicaid Wraparound paid the drug in full, leave blank.</p> <p>ADMINISTRACION DE SEGUROS DE SALUD,  23 - 0 0 0 4 66</p> <p>Contrato Número</p>

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidelines for PRIMIS	PRIMIS Instructions
			<p>06 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (13E-JJM) as reported by previous payer.</p> <p>08 – Amount Attributed to Health Plan Assistance Amount (12B-JJD) as reported by previous payer.</p> <p>10 – Amount Attributed to Provider Network Selection.</p>	

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ADMINISTRACION DE  
SEGUROS DE SALUD,

23 - 000466

Contrato Número

**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	PRMIS 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.  ADMINISTRACION DB SEGUROS DE SALUD 23 - 000466  Contrato Número	MACSNP If the MAO pays for a drug, Field #232 must indicate Primary Payer ID MACSNP. MACSNP 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'.

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMIS Instructions
			<p>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.</p> <p><b>COMMERCIAL</b> (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.</p> <p><b>TRICARE</b> (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'.</p>	
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.	<p><b>ADMINISTRACION DB SEGUROS DE SALUD</b> <b>23 - 000466A</b> <b>Contrato Número</b></p>	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.		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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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMIS Instructions
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #228 is required when the Commercial Health Insurance Plan did not assess deductible, do not report.  Field #238 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.
230	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.	ADMINISTRACION DE SEGUROS DE SALUD  23 - 00046A  Contrato Número	Field #230 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	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.  MEDGAP If the Payer 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 insurance 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 Field Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMS Instructions
			<p>Medicare gap insurance is always secondary to Medicare or an MAO.</p> <p>MEDGAP represents an insurance plan that covers only Medicare/MAO cost sharing.</p> <p><b>MEDICAID</b></p> <p>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'.</p> <p>MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product.</p> <p>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.</p> <p><b>COMMERCIAL</b></p> <p>(This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.)</p> <p>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.</p> <p>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.</p> <p><b>TRICARE</b></p> <p>(This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.)</p> <p>If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #238 must indicate Secondary Payer ID 'TRICARE'.</p>	<p>report the secondary payer ID as 'MAOSNP.'</p> <p style="text-align: right;">ADMINISTRACION DE SEGUROS DE SALUD , <b>23 - 000466</b>  Contrato Número</p>



NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMIS 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.
238	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.	ADMINISTRACION DE SEGUROS DE SALUD 23 - 00046A Contrato Número	Field #238 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.


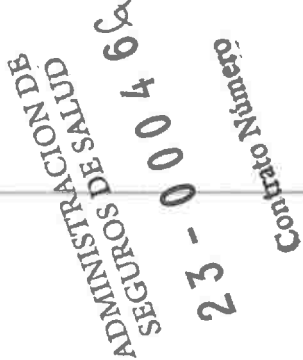
Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide



NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRAMIS Instructions
388- CB	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	<p>00 - Not Specified by patient.</p> <p>01 - No other coverage - Code used in coordination of benefits transactions to convey that no other coverage is available.</p> <p>02 - 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.</p> <p>03 - 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.</p> <p>04 - 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.</p> <p>05 - Claim is billing for patient financial responsibility only - Copy 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.</p>	<p>Field #308-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 02 when reporting the Commercial Health Insurance Plan as the primary payer.</p> <p><b>ADMINISTRACION DE SEGUROS DE SALUD</b></p> <p><b>23 - 0 0 0 4 66</b></p> <p><b>Contrato Número</b></p>
501- 01	PLAN TYPE	Identifies the type of plan: 1020 = Medicaid 1030 = Medicare Blank = Neither	Four spaces	Field #501-01 is REQUIRED. When Medicare Advantage is a secondary payer to a primary Commercial Health Insurance Plan, report 1030 (MEDICARE).
383- MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the Benefit Stage Amount' (384-MV)	<p>383-MV BENEFIT STAGE QUALIFIER</p> <p>Blank - Not Specified</p> <p>01 - Deductible - The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.</p> <p>02 - Initial Benefit - The first monthly benefit or the first monthly benefit following any break in participation.</p> <p>03 - 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</p>	Field #383-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 '04' (Fig Total Amount Paid, and 588-J5 Other Payer Amount Recognized) of the claim.




NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	PRMIS Instructions
	<p><i>Ad</i></p>	<p><b>NCPDP 4.2 Valid Values and Guidance</b></p> <p>limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount.</p> <p>04 - 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.</p> <p>50 - Not paid under Part D; paid under Part C benefit (for MA-PD plan):</p> <ul style="list-style-type: none"> <li>This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN.</li> <li>The claim is NOT paid by the Part D plan benefit.</li> <li>The claim IS paid for by Part C benefit (MA portion of the MA-PD).</li> <li>When the qualifier value of 50 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>The field 394-MY Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 565-J5 Other Payer Amount Recognized) of the claim.</li> <li>A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage.</li> </ul> <p>60 - Not paid under Part D; paid as or under a supplemental benefit only:</p> <ul style="list-style-type: none"> <li>This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where no pharmacy response is provided.</li> <li>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).</li> <li>The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.</li> </ul>	<p><i>POS</i></p> <p>ADMINISTRACION DE SEGUROS DE SALUD 23 - 00046A Contrato Número</p>



NCPDP 4.2 Field Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
 			<p><b>NCPDP 4.2 Valid Values and Guidance</b></p> <ul style="list-style-type: none"> <li>When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>The field 384-MV Benefit Stage Amount should be populated with the total amount (total of 508-F5 Patient Pay Amount, 508-F9 Total Amount Paid, and 508-J5 Other Payer Amount Recognized) of the claim.</li> <li>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:             <ol style="list-style-type: none"> <li>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 of 18. - Provide Notice: Medicare Prescription Drug Coverage and Your Rights.</li> <li>For non-Part D drug/non-qualified drugs Benefit Stage Qualifier 60 will be returned without the Approved Message Code value of 18.</li> </ol> </li> </ul> <p><b>Note:</b> Non-qualified drugs are defined as not meeting the definition of a Part D drug.</p> <p>61 - Part D drug not paid by Part D plan benefit, paid as or under a co-administered insured benefit only:</p> <ul style="list-style-type: none"> <li>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.</li> <li>The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit.</li> <li>When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>The field 384-MC Benefit Stage Amount should be populated with the total amount (total of 508-F5 Patient Pay Amount, 508-F9 Total Amount Paid, and 508-J5 Other Payer Amount Recognized) of the claim.</li> </ul>	

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	PRMMIS Instructions
		<p><b>NCPDP 4.2 YNM Values and Guidance</b></p> <p>62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only</p> <ul style="list-style-type: none"> <li>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.</li> <li>When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>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 566-J5 Other Payer Amount Recognized) of the claim.</li> </ul> <p>Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.</p> <p>70 – Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing:</p> <ul style="list-style-type: none"> <li>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.).</li> <li>When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>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 566-J5 Other Payer Amount Recognized) of the claim.</li> <li>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 (548-8F) must be returned with a value of 18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights."</li> </ul>	<p>ADMINISTRACION DE SEGUROS DE SALUD, 23 - 000466 Contrato Número</p>
			

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.3 Instructions	NCPDP 4.3 Valid Values and Guidance	PRMIS Instructions
			<p><b>802 – 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:</b></p> <ul style="list-style-type: none"> <li>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).</li> <li>When the qualifier value of 802 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>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 566-J5 Other Payer Amount Recognized) of the claim.</li> </ul> <p><b>902 – Enhance or OTC drug (PDE value of E/C) not applicable to the Part D drug spend, but is covered by the Part D plan:</b></p> <ul style="list-style-type: none"> <li>When the qualifier value of 902 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</li> <li>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 566-J5 Other Payer Amount Recognized) of the claim.</li> <li>Code qualifying the 'Benefit Stage Amount' (394-MV).</li> </ul>	

ADMINISTRACION DB  
SEGUROS DE SALUD  
23 - 000464  
Contrato Número



NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMIS 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 Q1 - Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Q2 - Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Q3 - Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Q4 - Amount Exceeding Periodic Benefit Maximum (528-PK) as reported by previous payer. Q5 - Amount of Copay (51B-FI) as reported by previous payer. Q6 - Patient Pay Amount (525-F5) as reported by previous payer. Q7 - Amount of Coinsurance (572-4U) as reported by previous payer. Q8 - Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-LM) as reported by previous payer. Q9 - Amount Attributed to Health Plan Assistance Amount (129-JD) as reported by previous payer. Q2 - 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 Q6.

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ADMINISTRACION DE  
 SEGUROS DE SALUD,  
 23 - 000464  
 Contrato Número

**Appendix B: Change Summary**

Version	Issue Date	Modified By	Comments/Reason
1.0	02/16/2017	WR Joslyn	Original document with formatting updates.
2.0	08/30/2017	WR Joslyn	<p>Page 159: Added the following text to the 887 -- 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."</p> <p>Page 162: Updated the 888 -- 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."</p> <p>Page 193: Removed "ORIGINAL TRANSACTION ID" and "VOIDED TRANSACTION IDENTIFIER" rows.</p> <p>Changed the following FILLER row values to:                      Length to 423.                      Start position from 3314 to 3298.</p>
3.0	12/15/2018	WR 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	<p>Transaction Specific Information</p> <p>Column header "Mandatory or Situational" changed to "Usage" and new usage type added "NU" for "Fields Not Used" by PRMMIS.</p> <p>All fields that are used by PRMMIS during processing are identified as "Required".</p> <p>Column header "PRDCH Requirement" changed to "PRMP Comment".</p>
		Page 7	<p>Header Record</p> <p>Field 879 "Sending entity identifier" value changed to "PRMP assigned six-digit trading partner ID."</p>
		Page 8	Field 888-K7 -- "Receiver ID" value changed to "PRMMIS."
		Page 9	Detail Record starts.

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SEGUROS DE SALUD

23 - 000469

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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Version	Issue Date	Modified By	Comments/Reason
		Page 10	Field 302-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 720-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 (06).
		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 304-C4 comment changed to "Required when available in the payer's adjudication system."
		Page 12	Field 305-C5 is not used by PRMMIS.
		Page 12	Field 247 is not used by PRMMIS.
		Page 12	Field 208 is not used by PRMMIS.
		Page 13	Field 303-C3 is not used by PRMMIS.
		Page 13	Field 306-C6 is not used by PRMMIS.
		Page 13	Field 309-C9 is not used by PRMMIS.
		Page 13	Field 215 Comment changed to "PRMP assigned trading partner ID of MCCYMAQ."

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ADMINISTRACION DE  
SEGUROS DE SALUD

23-000464

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Contrato Número

Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Version	Issue Date	Modified by	Comments/Reason
		Page 13	Field 212 is not used by PRMMIS.
		Page 13	Field 278 is not used by PRMMIS.
		Page 14	Field 282 is not used by PRMMIS - all three.
		Page 14	Field 282 is not used by PRMMIS.
		Page 14	Field 308-C6 Comment changed to "If available, report the appropriate value that represents other coverage for the drug/product."
		Page 16	Field 601-01 added value "If neither MAO nor Wraparound is the primary payer, enter four spaces" and Comment changed to "Use 1930 (Medicare) when only MAO funding is used to pay the drug/product. Use 1920 (Medicaid) when only Puerto Rico Medicaid funds are used to pay the drug/product. If neither, enter spaces."
		Page 17	Field 202-82 Value shortened to "01 - National Provider Identifier (NPI), 05 - Medicaid ID if atypical" and Comment shortened to "Required."
		Page 17	Field 201-81 Comment shortened to "Required."
		Page 17	Field 202-82 is not used by PRMMIS.
		Page 17	Field 201-B1 is not used by PRMMIS.
		Page 17	Field 727-55 is not used by PRMMIS.
		Page 18	Field 732 is not used by PRMMIS.
		Page 19	Field B10-8A is not used by PRMMIS.
		Page 19	Field 150 is not used by PRMMIS.
		Page 18	Field 266 is not used by PRMMIS.
		Page 18	Field 488-EZ is not used by PRMMIS.
		Page 18	Field 411-DB is not used by PRMMIS.
		Page 18	Field 286 comment changed to "Required when available in the payer's adjudication system."
		Page 18	Field 286 is not used by PRMMIS.
		Page 19	Field 718-SY is required by PRMMIS.
		Page 19	Field 717-SX is required by PRMMIS.
		Page 19	Field B10-8A is required by PRMMIS.

  
 ADMINISTRACION DE  
 SEGUROS DE SALUD  
 23 - 000460  
 Contacto Numero

Puerto Rico Medicaid Program  
 NCPDP Post Adjudication Companion Guide

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 307-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 102-A2 is not used by PRMMIS.
		Page 24	Field 216 is not used by PRMMIS.
		Page 26	Field 428-DT is not used by PRMMIS.
		Page 26	Field 600-28 is not used by PRMMIS.
		Page 27	Field 254 is not used by PRMMIS.
		Page 27	Field 906-G1 is not used by PRMMIS.
		Page 28	Field 492-WE PRMMIS will only use one Diagnosis Code.
		Page 28	Field 424-OO PRMMIS will only use one diagnosis Code.
		Pages 29 - 35	All 439-EA, 440-EE, 441-EB, & 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, & 281 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, 420-OK, is used by PRMMIS.
		Page 36 - 73	Fields 601-24, 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 601-19 & 601-18 are not used by PRMMIS.
		Page 38 - 85	All 601-26 & 601-25 fields are not used by PRMMIS.
		Page 38 - 91	Fields 257, 221, 889, 268, & 256 are not used by PRMMIS.

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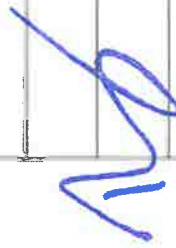
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Puerto Rico Medicaid Program  
NCPDP Post Adjudication Companion Guide

Version	Issue Date	Modified By	Comments/Reason
		Page 40 - 91	Fields 572-4U, 519-FJ, 517-FH, 571-NZ, 133-UJ, 134-LJK, 135-UM, 136-UN, 137-UP, 272, 223, 283, 284, 289, 210, 211, & 253 are not used by PRMMIS.
		Page 43	Field 551-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, 287, 481-EU, 482-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 SMP would be considered the primary payer when the Payer 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 Payer Member's cost sharing."
		Page 58	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 copayment that was assessed on the drug/product."
		Page 58	Field 238 has a new comment, "Required when there is a Secondary Payer copayment that was assessed on the drug/product."
		Page 58	Field 597-G2 is not used by PRMMIS.
		Page 58 - 59	Only the first pair of fields, 393-MV & 384-MW are used by PRMMIS.
		Page 80	Field 302-C2 is not used by PRMMIS.
		Page 60	Field 475-J9 is not used by PRMMIS.

  
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Puerto Rico Medicaid Program  
 NCPDP Post Adjudication Companion Guide

Version	Issue Date	Modified By	Comments/Reason
		Page 62	Field 351-HP 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 250 is not used by PRMMIS.
		Page 76	Field 251 is not used by PRMMIS.
		Page 88	Field 475-JB is not used by PRMMIS.
		Page 90	Fields 47B-HB & 87B 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.
4.0	11/18/2020	Gainwell Technologies	Gainwell Rebranding

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