

Express Scripts, Inc. NCPDP Version 5.1 Payer Sheet Medicare Part D

Claim transaction segments not depicted within this document may be accepted in the transmission of a claim. However, Express Scripts may not use the information submitted to adjudicate claims.

General Information:

| | |
|--|-------------------------------|
| Payer Name: Express Scripts, Inc. | Date: January 01, 2010 |
| Plan Name/Group Name: Express Scripts, Inc. – Medicare Part D Plans | |
| Processor: Express Scripts, Inc. | Switch: |
| Effective: January 1, 2007 | Version/Release Number: 5.2 |
| Contact/Information Source: Network Contracting and Management Account Manager, or (800) 824-0898, or www.express-scripts.com | |
| Testing Window: No testing required for Medicare Claim billings and reversals. | |
| Provider Relations Help Desk Info: (800) 824-0898 | |
| Other versions supported: N/A | |

ESI supports a B1 Billing claim transaction and a B2 Reversal claim transaction. Only one Medicare claim may be submitted per transaction to eliminate confusion in the calculation of TrOOP.
See the TRICARE (Department of Defense) for added requirements for Medicare Part D COB claim, specifically the addition of Field 433-DX to the pricing segment.

Please see the following pages for additional details regarding the transaction sections of the payer sheet.

Partial fill Medicare claims are not accepted if beneficiary has other payer coverage. Reject message will display as such: Reject code RK "Partial Fill Transaction not supported."

| DATE | ADDITION | | | | | | | | | | | | | | | | | | |
|---|---|---|-------------------|-----------------|------------------------|--|---|---|---|---|------------------|---|----------------|---------|---|----------------|------------------|--|----------------|
| January 1, 2010 | Prescription Origin Code: Pharmacies may no longer submit Ø as a valid value in NCPDP Field 419-DJ. Accepted values for this field are: 1=Written Prescription; 2=Telephone; 3=Electronic (e-prescribed); 4=Facsimile. CMS also requires pharmacy providers to track all new Medicare Part D prescriptions transmitted via e-prescribing as of Jan. 1, 2010 by submitting a value of "3" in field 419-DJ. | | | | | | | | | | | | | | | | | | |
| January 1, 2010 | New secondary messaging to clarify existing Transition fill Global Prior Authorization Codes 5386, 5387, 5388, 5389 and 5390. | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <thead> <tr> <th>Reject Code</th> <th>Secondary Message</th> <th>Pharmacy Action</th> </tr> </thead> <tbody> <tr> <td>E7 (M/I QTY Dispensed)</td> <td>"Max QTY = xx TABS PER xx DAYS, THIS IS A TRANSITION FILL; REDUCE QUANTITY AND SUBMIT PA 5388"</td> <td>Reduce quantity and submit PA 5388 for Formulary drug w/QLL</td> </tr> <tr> <td>70 (Product/Service Not Covered) & E7 (M/I QTY Dispensed)</td> <td>"MAND FORM: XXX, THIS IS A TRANSITION FILL; REDUCE QUANTITY AND SUBMIT PA 5389"</td> <td>Reduce quantity and submit PA 5389 for Non-Formulary drug w/QLL</td> </tr> <tr> <td>75 (PA Required)</td> <td>"THIS IS A TRANSITION FILL, SUBMIT PA 5390"</td> <td>Submit PA 5390</td> </tr> <tr> <td>70 & E7</td> <td>"THIS IS A TRANSITION FILL, SUBMIT PA 5387"</td> <td>Submit PA 5387</td> </tr> <tr> <td>75 (PA Required)</td> <td>"THIS IS A TRANSITION FILL, SUBMIT A 5386"</td> <td>Submit PA 5386</td> </tr> </tbody> </table> | Reject Code | Secondary Message | Pharmacy Action | E7 (M/I QTY Dispensed) | "Max QTY = xx TABS PER xx DAYS, THIS IS A TRANSITION FILL; REDUCE QUANTITY AND SUBMIT PA 5388" | Reduce quantity and submit PA 5388 for Formulary drug w/QLL | 70 (Product/Service Not Covered) & E7 (M/I QTY Dispensed) | "MAND FORM: XXX, THIS IS A TRANSITION FILL; REDUCE QUANTITY AND SUBMIT PA 5389" | Reduce quantity and submit PA 5389 for Non-Formulary drug w/QLL | 75 (PA Required) | "THIS IS A TRANSITION FILL, SUBMIT PA 5390" | Submit PA 5390 | 70 & E7 | "THIS IS A TRANSITION FILL, SUBMIT PA 5387" | Submit PA 5387 | 75 (PA Required) | "THIS IS A TRANSITION FILL, SUBMIT A 5386" | Submit PA 5386 |
| Reject Code | Secondary Message | Pharmacy Action | | | | | | | | | | | | | | | | | |
| E7 (M/I QTY Dispensed) | "Max QTY = xx TABS PER xx DAYS, THIS IS A TRANSITION FILL; REDUCE QUANTITY AND SUBMIT PA 5388" | Reduce quantity and submit PA 5388 for Formulary drug w/QLL | | | | | | | | | | | | | | | | | |
| 70 (Product/Service Not Covered) & E7 (M/I QTY Dispensed) | "MAND FORM: XXX, THIS IS A TRANSITION FILL; REDUCE QUANTITY AND SUBMIT PA 5389" | Reduce quantity and submit PA 5389 for Non-Formulary drug w/QLL | | | | | | | | | | | | | | | | | |
| 75 (PA Required) | "THIS IS A TRANSITION FILL, SUBMIT PA 5390" | Submit PA 5390 | | | | | | | | | | | | | | | | | |
| 70 & E7 | "THIS IS A TRANSITION FILL, SUBMIT PA 5387" | Submit PA 5387 | | | | | | | | | | | | | | | | | |
| 75 (PA Required) | "THIS IS A TRANSITION FILL, SUBMIT A 5386" | Submit PA 5386 | | | | | | | | | | | | | | | | | |
| | Following the beneficiary's transition period, global override codes are no longer available. | | | | | | | | | | | | | | | | | | |

Field Status: M=Mandatory, O=Optional; will be returned when applicable,
R=Required by ESI to expedite claim processing, "R"=Repeating Field

Express Scripts, Inc. NCPDP Version 5.1 Payer Sheet Medicare Part D

Section: Billing Transaction (In Bound)

NOTE: The Transaction Header Segment is the only FIXED length portion of the NCPDP version 5.1 record. All 56 bytes must accompany the transaction along with the following defined rules:

- If numeric - Right justify; zero fill.
- If alphanumeric - Left justify; space fill.

Transaction Header Segment - Mandatory in all cases.

| Field # | NCPDP Field Name | Value | Field Status |
|---------|----------------------------------|-----------------------------------|--------------|
| 101-A1 | Bin Number | 003858 | M |
| 102-A2 | Version Release Number | 51=Version 5.1 | M |
| 103-A3 | Transaction Code | B1=Billing | M |
| 104-A4 | Processor Control Number* | A4 For Secondary Payer use SC* | M |
| 109-A9 | Transaction Count | 1=One Occurrence | M |
| 202-B2 | Service Provider ID Qualifier | 01=NPI | M |
| 201-B1 | Service Provider ID | NPI | M |
| 401-D1 | Date of Service | | M |
| 110-AK | Software Vendor/Certification ID | | M |

* If submitting supplemental prescription claims to ESI as a secondary payer for Medicare Part D, the PCN must be designated "SC."

Patient Segment - Segment is optional, but ESI requires some fields to expedite claim processing.

| Field # | NCPDP Field Name | Value | Field Status |
|---------|---------------------------|--|--------------------------------|
| 111-AM | Segment Identification | 01=Patient | M |
| 304-C4 | Date of Birth | | R |
| 305-C5 | Patient Gender Code | 1=Male 2=Female | R |
| 310-CA | Patient First Name | | R |
| 311-CB | Patient Last Name | | R |
| 322-CM | Patient Street Address | | R |
| 323-CN | Patient City | | R |
| 324-CO | Patient State or Province | | R |
| 325-CP | Patient Zip/Postal Code | | R |
| 307-C7 | Patient Location* | 0=Not specified 3=Nursing Home 5=Rest Home | R For LTC Providers Only |

* Field 307-C7 (Patient Location) is a required field to identify where a Medicare beneficiary resides. If an LTC facility or a Retail Pharmacy servicing an LTC Medicare Part D Beneficiary, please identify by using a value of 3. Use a value of 5 when identifying a beneficiary residing in an Assisted Living facility to ensure proper adjudication and payment. When servicing a retail customer, pharmacies that provide both retail and long term care services must indicate a zero (0) value when submitting a claim for a non-LTC beneficiary. If a value of one (1) or no value is indicated, the claim will reject with a reject 12, M/I Patient Location.

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Insurance Segment - Mandatory

| Field # | NCPDP Field Name | Value | Field Status |
|---------|--------------------------------|---|--------------|
| 111-AM | Segment Identification | Ø4=Insurance | M |
| 3Ø2-C2 | Cardholder ID | ID assigned to the cardholder. | M |
| 312-CC | Cardholder First Name | | R |
| 313-CD | Cardholder Last Name | | R |
| 3Ø9-C9 | Eligibility Clarification Code | Ø=Not Specified | R |
| 3Ø1-C1 | Group ID | As appears on card. | R |
| 3Ø3-C3 | Person Code | | R |
| 3Ø6-C6 | Patient Relationship Code | Ø=Not Specified 1=Cardholder 2=Spouse | R |

Claim Segment - Mandatory

| Field # | NCPDP Field Name | Value | Field Status |
|---------|--|---|--------------|
| 111-AM | Segment Identification | Ø7=Claim | M |
| 455-EM | Prescription/Service Reference Number Qualifier | 1=Rx Billing* *Pharmacist should enter a "1" when processing a claim for a Medicare Part D vaccine drug and vaccine administration. | M |
| 4Ø2-D2 | Prescription/Service Reference Number | | M |
| 436-E1 | Product/Service ID Qualifier | Ø3=National Drug Code | M |
| 4Ø7-D7 | Product/Service ID | | M |
| 442-E7 | Quantity Dispensed | | R |
| 4Ø3-D3 | Fill Number | Ø=Original Dispensing 1 to 99 = Refill number | R |
| 4Ø5-D5 | Days Supply | | R |
| 4Ø6-D6 | Compound Code | 1=Not a Compound 2=Compound – submit highest cost legend ingredient NDC in field 4Ø7-D7 | R |
| 4Ø8-D8 | Dispense as Written (DAW)/Product Selection Code | Ø= No Product Selection Indicated -This is the field default value that is appropriately used for prescriptions where product selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed. 1= Substitution Not Allowed by Prescriber -This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written. 2= Substitution Allowed-Patient Requested Product Dispensed -This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the | R |

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| | | <p>patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.</p> <p><u>3=Substitution Allowed-Pharmacist Selected Product Dispensed</u>-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.</p> <p><u>4=Substitution Allowed-Generic Drug Not in Stock</u>-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.</p> <p><u>5=Substitution Allowed-Brand Drug Dispensed as a Generic</u>-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity.</p> <p><u>6=Override</u>-This value is used by various claims processors in very specific instances as defined by that claims processor and/or its client(s).</p> <p><u>7=Substitution Not Allowed-Brand Drug Mandated by Law</u>-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.</p> <p><u>8=Substitution Allowed-Generic Drug Not Available in Marketplace</u>-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable.</p> | |
|--|--|--|--|

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|--------|-------------------------------|---|--|
| | | 9=Other-This value is reserved and currently not in use. NCPDP does not recommend use of this value at the present time. Please contact NCPDP if you intend to use this value and document how it will be utilized by your organization. | |
| 414-DE | Date Prescription Written | | R |
| 415-DF | Number of Refills Authorized | Ø=Not Specified 1 through 99, with 99 being as needed, refills unlimited | R |
| 419-DJ | Prescription Origin** | 1=Written Prescription 2=Telephone 3= Identify all e-Prescribing events 4=Facsimile | R |
| 420-DK | Submission Clarification Code | 4= Lost prescription – The pharmacist is indicating that the cardholder has requested replacement of medication that has been lost 6= Starter Dose – The pharmacist is indicating that the previous medication was a starter dose and additional medication is now needed to continue treatment | O |
| 3Ø8-C8 | Other Coverage Code | Ø=Not Specified 1=No other coverage identified 2=Other coverage exists-payment collected* 3=Other coverage exists-this claim not covered* 4=Other coverage exists-payment not collected* 5=Managed care plan denial* 6=Other coverage denied-not a participating provider* 7=Other coverage exists-not in effect at time of service* | R *Requires COB segment to be sent. |
| 418-DI | Level of Service | 3=Emergency | O |
| 462-EV | Prior Auth Number Submitted+ | Submitted when requested by processor. | R |

**Beginning Jan. 1, 2010, the accepted "Prescription Origin" field 419 DJ values are 1 through 4 as noted in the table below. Pharmacies must also consistently use "3" to identify all e-prescribing events, since CMS (and ESI) require this tracking effective Jan. 1, 2010.

| Value | Description |
|-------|----------------------|
| 1 | Written Prescription |
| 2 | Telephone |
| 3 | Electronic |
| 4 | Facsimile |

Global Prior Authorization codes permitted during a Medicare Part D beneficiary's transition period are shown on the following page. Message will appear in Response Message field 504-54. The pharmacist will need to enter the Global Prior Authorization Code in the Prior Auth Number Submitted field, 462-EV, and resubmit the claim. After the transition period, these Global Prior Authorization Codes will no longer be available.

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| Reject Code | Secondary Message | Pharmacy Action |
|---|--|---|
| E7 (M/I QTY Dispensed) | "Max QTY = xx TABS PER xx DAYS, THIS IS A TRANSITION FILL; REDUCE QUANTITY AND SUBMIT PA 5388" | Reduce quantity and submit PA 5388 for Formulary drug w/QLL |
| 70 (Product/Service Not Covered) & E7 (M/I QTY Dispensed) | "MAND FORM: XXX, THIS IS A TRANSITION FILL; REDUCE QUANTITY AND SUBMIT PA 5389" | Reduce quantity and submit PA 5389 for Non-Formulary drug w/QLL |
| 75 (PA Required) | "THIS IS A TRANSITION FILL, SUBMIT PA 5390" | Submit PA 5390 |
| 70 & E7 | "THIS IS A TRANSITION FILL, SUBMIT PA 5387" | Submit PA 5387 |
| 75 (PA Required) | "THIS IS A TRANSITION FILL, SUBMIT A 5386" | Submit PA 5386 |

Override codes 5388 and 5389 require pharmacist to:

1. Change the quantity to the amount indicated in the message (e.g. MAX QTY=X) when Reject E7 or 70 is received.
2. Enter the code.

Override code 5390 authorizes a one-time courtesy fill for a first-line drug, after which the beneficiary must use the second-line drug.

LTC Only Overrides- Refill-too-soon or Duplicate claim rejects:

Level of Service code field (418-DI) value=3 Emergency

Submission clarification code (field 420-DK) value=4 lost prescription, or 6=starter dose

No Quantity Level Limits (QLL) overrides are allowed in these situations.

Use the value "NP"=New Patient Processing in Reason for Service code (439-E4) If patient if a new admission with a new prescription, has transferred out of and back into LTC and/or upon re-admission refills reject as Refill-too-Soon(Reject 79).

Prescriber Segment - Required

| Field # | NCPDP Field Name | Value | Field Status |
|---------|-------------------------|--|--------------|
| 111-AM | Segment Identification | 03=Prescriber | M |
| 466-EZ | Prescriber ID Qualifier | 01=NPI 12=Drug Enforcement Agency (DEA) | R |
| 411-DB | Prescriber ID | DEA or NPI | R |

Express Scripts edits the qualifiers in field 466-EZ.

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COB/Other Payments Segment - Required

| Field # | NCPDP Field Name | Value | Field Status |
|---------|---|---|--------------|
| 111-AM | Segment Identification | Ø5=COB/Other Payments | M |
| 337-4C | Coordination of Benefits/Other Payments Count | Value=1 | M |
| 338-5C | Other Payer Coverage Type | | M |
| 341-HB | Other Payer Amount Paid Count | Value=1 | R |
| 342-HC | Other Payer Amount Paid Qualifier | Value= Ø8 | R |
| 431-DV | Other Payer Amount Paid | Valid value of \$Ø or greater to reflect appropriate Other Payer Amount | R |

The COB segment and all required fields must be sent if the Other Coverage Code (308-C8) field with values = 1-7 is submitted in the claim segment.

DUR/PPS Segment - Required

| Field # | NCPDP Field Name | Value | Field Status |
|---------|---------------------------|--|--------------|
| 111-AM | Segment Identification | Ø8=DUR/PPS | M |
| 473-7E | DUR/PPS Code Counter | Value=1 Rx Billing* | R |
| 439-E4 | Reason for Service Code | DA=Drug-Allergy DC=Drug-Disease (Inferred) DD=Drug-Drug Interaction HD=High Dose (Maximum Daily Dose) ID=Ingredient Duplication LD=Low Dose (Minimum Daily Dose) PG=Drug-Pregnancy SX=Drug-Gender TD=Therapeutic Duplication **NP= New Patient Processing – LTC providers only: To override the Refill-too-Soon Reject (79), enter value "NP". | R |
| 44Ø-E5 | Professional Service Code | ØØ=No intervention MØ=Prescriber consulted PE=Patient education/instruction PØ=Patient consulted RØ=Pharmacist consulted other source MA=Medication Administered – indicates the administration of a Part D covered vaccine* | R |

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| | | | |
|--------|-------------------------|--|---|
| 441-E6 | Result of Service Code | ØØ=Not Specified 1A=Filled As Is, False Positive 1B=Filled Prescription As Is 1C=Filled, With Different Dose 1D=Filled, With Different Directions 1E=Filled, With Different Drug 1F=Filled, With Different Quantity 1G=Filled, With Prescriber Approval 2A=Prescription Not Filled 2B=Not Filled, Directions Clarified 3C=Discontinued Drug 3E=Therapy Changed 3H=Follow-Up/Report | R |
| 474-8E | DUR/PPS Level of Effort | Ø=Not Specified 11=Level 1 (Lowest) 12=Level 2 13=Level 3 14=Level 4 15=Level 5 (Highest) | R |

* Indicates the claim billing includes a charge for the administration of the vaccine.

**Use the value "NP"=New Patient Processing in Reason for Service code (439-E4) If patient if a new admission with a new prescription, has transferred out of and back into LTC and/or upon re-admission refills reject as Refill-too-Soon(Reject 79).

Field Status: M=Mandatory, O=Optional; will be returned when applicable,
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**Express Scripts, Inc.
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Pricing Segment - Mandatory

| Field # | NCPDP Field Name | Value | Field Status |
|---------|-----------------------------|---|--------------|
| 111-AM | Segment Identification | 11=Pricing | M |
| 409-D9 | Ingredient Cost Submitted | | R |
| 412-DC | Dispensing Fee Submitted | | R |
| 426-DQ | Usual and Customary Charge | Vaccine Drug Cost + Vaccine Administration Fee* | R |
| 430-DU | Gross Amount Due | | R |
| 423-DN | Basis of Cost Determination | | R |
| 438-E3 | Incentive Fee Submitted | Vaccine Administration Fee* | R |

*The dollar amount in field 438-E3 will be deducted from the U&C field 426-DQ to determine the cost of the vaccine drug only. These two fields must be populated correctly to ensure accurate payment to the pharmacy.

Section: Billing Response Transaction (Out Bound)

Response Header Segment - Mandatory

| Field # | NCPDP Field Name | Value | Field Status |
|---------|-------------------------------|--------------------------|--------------|
| 102-A2 | Version Release Number | 51=Version 5.1 | M |
| 103-A3 | Transaction Code | B1=Billing | M |
| 109-A9 | Transaction Count | 1=One Occurrence | M |
| 501-F1 | Header Response Status | A=Accepted R=Rejected | M |
| 202-B2 | Service Provider ID Qualifier | 01=NPI | M |
| 201-B1 | Service Provider ID | NPI | M |
| 401-D1 | Date of Service | | M |

Response Message Segment - Optional

| Field # | NCPDP Field Name | Value | Field Status |
|---------|------------------------|---------------------|--------------|
| 111-AM | Segment Identification | 20=Response Message | M |
| 504-F4 | *Message | * | O |

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Response Status Segment - Mandatory

| Field # | NCPDP Field Name | Value | Field Status |
|---------|----------------------------------|--|--------------|
| 111-AM | Segment Identification | 21=Response Status | M |
| 112-AN | Transaction Response Status | P=Paid R=Rejected D=Duplicate of Paid | M |
| 503-F3 | Authorization Number | | R |
| 510-FA | Reject Count* | * Required if Transaction Response Status=R. | O |
| 511-FB | Reject Code* | * Required if Transaction Response Status=R. | O"R" |
| 526-FQ | Additional Message Info | | O |
| 549-7F | Help Desk Phone Number Qualifier | | O |
| 550-8F | Help Desk Phone Number | | O |

*Medicare Part D Drug Program: As part of the Medicare Part D Drug Program, the primary program messaging design will reference field (526-FQ) with the generic savings delta to the pharmacy when a brand drug is dispensed. Field (526-FQ) will note: "CMS estimated brand/generic difference: XXX.XX."

In addition, the beneficiary with other payer coverage will be identified in fields 504-F4 and if needed, field 526-FQ. At no time will the eligibility information be split between the 2 message fields. If the eligibility information can not be completed in the first message field without being split, it will move to the second message field (526-FQ). A standard response format has been established. The TrOOP facilitator has defined that standard.

Response Claim Segment - Mandatory

| Field # | NCPDP Field Name | Value | Field Status |
|---------|---|-------------------|--------------|
| 111-AM | Segment Identification | 22=Response Claim | M |
| 455-EM | Prescription/Service Reference Number Qualifier | 1=Rx Billing | M |
| 402-D2 | Prescription/Service Reference Number | | M |

Response Pricing Segment - Mandatory* This segment will not be included with a rejected response.

| Field # | NCPDP Field Name | Value | Field Status |
|---------|----------------------------------|---|--------------|
| 111-AM | Segment Identification | 23=Response Pricing | M |
| 505-F5 | Patient Pay Amount | | R |
| 506-F6 | Ingredient Cost Paid | | R |
| 507-F7 | Dispensing Fee Paid | | R |
| 557-AV | Tax Exempt Indicator | | R |
| 558-AW | Flat Sales Tax Amount Paid | | O |
| 559-AX | Percentage Sales Tax Amount Paid | | O |
| 560-AY | Percentage Sales Tax Rate Paid | | O |
| 561-AZ | Percentage Sales Tax Basis Paid | 02=Ingredient Cost 03=Ingredient Cost + Dispensing Fee | O |
| 521-FL | Incentive Amount Paid | | O |
| 566-J5 | Other Payer Amount Recognized | | O |
| 509-F9 | Total Amount Paid | | R |

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| | | | |
|--------|---|--|---|
| 522-FM | Basis of Reimbursement Determination | Ø1=Ingredient Cost as submitted Ø2=Ingredient Cost reduced to AWP pricing Ø3=Ingredient Cost reduced to AWP less x% pricing Ø4=Paid lower of (Ingredient Cost + Fee) vs. U&C Ø6=Mac pricing Ingredient Cost Paid Ø7=Mac Pricing Ingredient Cost reduced to MAC Ø8=Contract pricing | R |
| 523-FN | Amount Attributed to Sales Tax | | 0 |
| 512-FC | Accumulated Deductible Amount | | 0 |
| 513-FD | Remaining Deductible Amount | | 0 |
| 514-FE | Remaining Benefit Amount | | 0 |
| 517-FH | Amount Applied to Periodic Deductible | | 0 |
| 518-FI | Amount of Copay/Coinsurance | | 0 |
| 519-FJ | Amount Attributed to Product Selection | | 0 |
| 52Ø-FK | Amount Exceeding Periodic Benefit Maximum | | 0 |

Response DUR/PPS Segment - Optional

| Field # | NCPDP Field Name | Value | Field Status |
|---------|-------------------------------|--|--------------|
| 111-AM | Segment Identification | 24 = Response DUR/PPS | M |
| 567-J6 | DUR/PPS Response Code Counter | | 0 |
| 439-E4 | Reason for Service Code | DA=Drug-Allergy DC=Drug-Disease (Inferred) DD=Drug-Drug Interaction HD=High Dose (Maximum Daily Dose) ID=Ingredient Duplication LD=Low Dose (Minimum Daily Dose) PG=Drug-Pregnancy SX=Drug-Gender TD=Therapeutic Duplication NP= New Patient Processing – LTC providers only: *To override the Refill-too-Soon reject (79), enter value "NP" | 0 |
| 528-FS | Clinical Significance Code | | 0 |
| 529-FT | Other Pharmacy Indicator | | 0 |
| 531-FV | Quantity of Previous Fill | | 0 |
| 53Ø-FU | Previous Date of Fill | | 0 |
| 532-FW | Database Indicator | | 0 |
| 533-FX | Other Prescriber Indicator | | 0 |
| 544-FY | DUR Free Text Message | | 0"R" |

*Use the value "NP"= Patient Processing in Reason for Service Code (439-E4) if patient is a new admission with a new prescription, has transferred out of and back into an LTC facility, and upon re-admission their refills reject as Refill-too-Soon (Reject 79).

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Section: Reversal Transaction (In Bound)

Transaction Header Segment - Mandatory

| Field # | NCPDP Field Name | Value | Field Status |
|---------|----------------------------------|--|--------------|
| 101-A1 | Bin Number | 003858 (Or as Assigned by ESI) | M |
| 102-A2 | Version Release Number | 51=Version 5.1 | M |
| 103-A3 | Transaction Code | B2=Reversal | M |
| 104-A4 | Processor Control Number | Assigned by ESI | M |
| 109-A9 | Transaction Count | 1=One Occurrence, one reversal per B2 transmission | M |
| 202-B2 | Service Provider ID Qualifier | 01=NPI | M |
| 201-B1 | Service Provider ID | NPI | M |
| 401-D1 | Date of Service | | M |
| 110-AK | Software Vendor/Certification ID | | M |

Claim Segment - Mandatory

| Field # | NCPDP Field Name | Value | Field Status |
|---------|--|--|---|
| 111-AM | Segment Identification | 07=Claim | M |
| 445-EM | Prescription /Service Reference Number Qualifier | 1=Rx Billing | M |
| 402-D2 | Prescription/Service Reference Number | | M |
| 436-E1 | Product/Service ID Qualifier | 03=National Drug Code | R |
| 407-D7 | Product/Service ID | | R |
| 403-D3 | Fill Number | | R |
| 308-C8 | Other Coverage Code | 0=Not Specified 1=No other coverage identified 2=Other coverage exists-payment collected* 3=Other coverage exists-this claim not covered* 4=Other coverage exists-payment not collected* 5=Managed care plan denial* 6=Other coverage denied-not a participating provider* | R *Please use Other Coverage Code submitted on the original COB transaction. |

Field Status: M=Mandatory, O=Optional; will be returned when applicable,
R=Required by ESI to expedite claim processing, "R"=Repeating Field

**Express Scripts, Inc.
NCPDP Version 5.1 Payer Sheet
Medicare Part D**

Section: Reversal Response Transaction (Out Bound)

Response Header Segment - Mandatory

| Field # | NCPDP Field Name | Value | Field Status |
|---------|-------------------------------|---------------------------------------|--------------|
| 102-A2 | Version Release Number | 51=Version 5.1 | M |
| 103-A3 | Transaction Code | B2=Reversal | M |
| 109-A9 | Transaction Count | 1=One Occurrence, per B2 transmission | M |
| 501-F1 | Header Response Status | A=Accepted R=Rejected | M |
| 202-B2 | Service Provider ID Qualifier | 01=NPI | M |
| 201-B1 | Service Provider ID | NPI | M |
| 401-D1 | Date of Service | | M |

Response Message Segment - Optional

| Field # | NCPDP Field Name | Value | Field Status |
|---------|------------------------|---------------------|--------------|
| 111-AM | Segment Identification | 20=Response Message | M |
| 504-F4 | Message | | O |

Response Status Segment - Optional

| Field # | NCPDP Field Name | Value | Field Status |
|---------|----------------------------------|---|--------------|
| 111-AM | Segment Identification | 21=Response Status | M |
| 112-AN | Transaction Response Status | A=Approved R=Rejected | M |
| 510-FA | Reject Count | Required if Transaction Response Status=R | O |
| 511-FB | Reject Code | Required if Transaction Response Status=R | O"R" |
| 549-7F | Help Desk Phone Number Qualifier | | O |
| 550-8F | Help Desk Phone Number | | O |

Response Claim Segment - Mandatory

| Field # | NCPDP Field Name | Value | Field Status |
|---------|---|-------------------|--------------|
| 111-AM | Segment Identification | 22=Response Claim | M |
| 455-EM | Prescription/Service Reference Number Qualifier | 1=Rx Billing | M |
| 402-D2 | Prescription/Service Reference Number | | M |

Partial Fills:

Medicare claims are not accepted if beneficiary has other payer coverage. Reject message will display as such:
Reject code "RK"- partial fill transaction not supported.

Field Status: M=Mandatory, O=Optional; will be returned when applicable,
R=Required by ESI to expedite claim processing, "R"=Repeating Field