



## MaxCare Prescription Benefit Services Payer Specification Sheet

### GENERAL INFORMATION

Payer Name: <a href="#">MaxCare Prescription Benefit Services</a>		Date: <a href="#">08/01/2011</a>	
Plan Name/Group Name: <a href="#">ALL</a>		BIN: <a href="#">610170</a>	PCN: <a href="#">MRX</a>
Processor: <a href="#">SXC (ComCoTec) RxClaim</a>			
Effective as of: <a href="#">01/01/2012</a>		NCPDP Telecommunication Standard Version/Release #: <a href="#">D.0</a>	
NCPDP Data Dictionary Version Date: <a href="#">07/2007</a>		NCPDP External Code List Version Date: <a href="#">October 2009</a>	
Contact/Information Source: <a href="#">General website <a href="http://www.maxcarerx.com">www.maxcarerx.com</a></a>			
Certification Testing Window:			
Certification Contact Information:			
Provider Relations Help Desk Info: <a href="#">Pharmacy Help Desk: 800-259-7765</a>			
Other versions supported: <a href="#">NCPDP Telecommunication version 5.1 until 01/01/2012. Refer to the 5.1 payer sheet.</a>			

### OTHER TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name
B1	Billing Transaction
B2	Billing Reversal
B3	Rebilling

### FIELD LEGEND FOR COLUMNS

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

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

### CLAIM BILLING/CLAIM REBILL TRANSACTION

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

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

Field #	Transaction Header Segment <i>NCPDP Field Name</i>	Value	Payer Usage	Claim Billing/Claim Rebill <i>Payer Situation</i>
101-A1	BIN NUMBER	610170	M	
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1, B2, B3	M	Claim Billing, Claim Reversal, Claim Rebill
104-A4	PROCESSOR CONTROL NUMBER	MRX	M	
109-A9	TRANSACTION COUNT	01 - 04	M	Up to 4 transactions per B1 & B3 Transmissions accepted
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M	
201-B1	SERVICE PROVIDER ID	Value for the qualifier in 202-B2	M	
401-D1	DATE OF SERVICE	CCYYMMDD	M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Use value for Switch's requirements. If submitting claim without a Switch, populate with blanks.



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

Insurance Segment Segment Identification (111-AM) = "Ø4"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø2-C2	CARDHOLDER ID		M	Member's ID as shown on card. Required
312-CC	CARDHOLDER FIRST NAME		RW	Not Required
313-CD	CARDHOLDER LAST NAME		RW	Not Required
314-CE	HOME PLAN		RW	Not Required
524-FO	PLAN ID		RW	Not Required
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE		RW	Not Required
3Ø1-C1	GROUP ID		RW	Required if needed for pharmacy claim processing and payment
3Ø3-C3	PERSON CODE		M	This information is located at the end of the Cardholder ID on the Benefit Card. Required
3Ø6-C6	PATIENT RELATIONSHIP CODE		RW	Not Required

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

Patient Segment Segment Identification (111-AM) = "Ø1"				Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
331-CX	PATIENT ID QUALIFIER		RW	Not Required
332-CY	PATIENT ID		RW	Not Required
3Ø4-C4	DATE OF BIRTH		M	Required
3Ø5-C5	PATIENT GENDER CODE		M	Required
31Ø-CA	PATIENT FIRST NAME		M	Required for Twins/Triplets/etc.
311-CB	PATIENT LAST NAME		RW	Not Required
322-CM	PATIENT STREET ADDRESS		RW	Not Required
323-CN	PATIENT CITY ADDRESS		RW	Not Required
324-CO	PATIENT STATE / PROVINCE ADDRESS		RW	Not Required
325-CP	PATIENT ZIP/POSTAL ZONE		RW	Not Required
326-CQ	PATIENT PHONE NUMBER		RW	Not Required
3Ø7-C7	PLACE OF SERVICE		RW	Not Required
333-CZ	EMPLOYER ID		RW	Not Required
335-2C	PREGNANCY INDICATOR		RW	Not Required
35Ø-HN	PATIENT E-MAIL ADDRESS		RW	Not Required
384-4X	PATIENT RESIDENCE		RW	Not Required

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

Claim Segment Segment Identification (111-AM) = "Ø7"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation



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	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER		RW	Not Required
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE		RW	Not Required
458-SE	PROCEDURE MODIFIER CODE COUNT		RW	Required ONLY if Procedure Modifier Code Submitted.
459-ER	PROCEDURE MODIFIER CODE		RW	<i>Payer Requirement:</i> Submit ONLY if instructed by Help Desk.
442-E7	QUANTITY DISPENSED		M	
4Ø3-D3	FILL NUMBER		M	
4Ø5-D5	DAYS SUPPLY		M	
4Ø6-D6	COMPOUND CODE	Ø1 = Not a Compound Ø2 = Compound	M	See Compound Segment for support of multi-ingredient compounds when compound = Ø2.
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		M	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED		RW	Not Required
419-DJ	PRESCRIPTION ORIGIN CODE		RW	Not Required
42Ø-DK	SUBMISSION CLARIFICATION CODE		RW	<i>Payer Requirement:</i> As needed to override a Reject (3 for Vacation Supply)
3Ø8-C8	OTHER COVERAGE CODE		RW	<i>Payer Requirement:</i> Only Required if Ø1 – Ø8 applies.
429-DT	SPECIAL PACKAGING INDICATOR		RW	Not Required
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER		RW	<i>Payer Requirement:</i> Not Required – Partial fills not supported
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE		RW	<i>Payer Requirement:</i> Not Required – Partial fills not supported
446-EB	ORIGINALLY PRESCRIBED QUANTITY		RW	<i>Payer Requirement:</i> Not Required – Partial fills not supported
454-EK	SCHEDULED PRESCRIPTION ID NUMBER		RW	Not Required
6ØØ-28	UNIT OF MEASURE		RW	Not Required
418-DI	LEVEL OF SERVICE		RW	Not Required
461-EU	PRIOR AUTHORIZATION TYPE CODE		RW	Not Required
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	Not Required
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID		RW	Not Required
464-EX	INTERMEDIARY AUTHORIZATION ID		RW	Not Required
343-HD	DISPENSING STATUS		RW	<i>Payer Requirement:</i> Not Required – Partial fills not supported
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	<i>Payer Requirement:</i> Not Required – Partial fills not supported
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	<i>Payer Requirement:</i> Not Required – Partial fills not supported
357-NV	DELAY REASON CODE		RW	<i>Payer Requirement:</i> Not Required – Partial fills not supported
391-MT	PATIENT ASSIGNMENT INDICATOR (DIRECT MEMBER REIMBURSEMENT INDICATOR)		RW	Not Required



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

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
409-D9	INGREDIENT COST SUBMITTED		M	
412-DC	DISPENSING FEE SUBMITTED		M	
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	Not Required
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW	Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		RW	Required if Other Amount Claimed Submitted (480-H9) is used.
480-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	Not Required
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		RW	Required if its value has an effect on the Gross Amount Due (430-DU) calculation.
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		RW	Required if its value has an effect on the Gross Amount Due (430-DU) calculation.
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		RW	Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used.  Required if this field could result in different pricing.
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		RW	Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used.
426-DQ	USUAL AND CUSTOMARY CHARGE		M	
430-DU	GROSS AMOUNT DUE		M	
423-DN	BASIS OF COST DETERMINATION		RW	Required if needed for receiver claim/encounter adjudication.

Pharmacy Provider Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<b>This segment is optional. Both fields are required to be provided when the segment is sent.</b>

	Pharmacy Provider Segment Segment Identification (111-AM) = "02"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
465-EY	PROVIDER ID QUALIFIER		RW	Required if segment is used.
444-E9	PROVIDER ID		RW	Required if segment is used.

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



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	<b>Prescriber Segment Segment Identification (111-AM) = "Ø3"</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
466-EZ	PRESCRIBER ID QUALIFIER		M	<i>Payer Requirement: Accepted Values Ø1 – NPI (Preferred value) 12 - DEA</i>
411-DB	PRESCRIBER ID		M	Required
427-DR	PRESCRIBER LAST NAME		RW	Not Required
498-PM	PRESCRIBER PHONE NUMBER		RW	Not Required
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER		RW	Not Required
421-DL	PRIMARY CARE PROVIDER ID		RW	Not Required
47Ø-4E	PRIMARY CARE PROVIDER LAST NAME		RW	Not Required
364-2J	PRESCRIBER FIRST NAME		RW	Not Required
365-2K	PRESCRIBER STREET ADDRESS		RW	Not Required
366-2M	PRESCRIBER CITY ADDRESS		RW	Not Required
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS		RW	Not Required
368-2P	PRESCRIBER ZIP/POSTAL ZONE		RW	Not Required

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

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

	<b>Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"</b>	<b>Billing/Reversal window is 45 days.</b>		<b>Claim Billing/Claim Rebill</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 3.	M	Scenario 1 - Other Payer Amount Paid Repetitions Only
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		RW	Required if segment is used.
34Ø-7C	OTHER PAYER ID		RW	Required if segment is used.
443-E8	OTHER PAYER DATE		RW	Required if segment is used.
471-5E	OTHER PAYER REJECT COUNT		RW	Required if segment is used.
472-6E	OTHER PAYER REJECT CODE		RW	Required if segment is used.
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT		RW	Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		RW	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	Required when billing for COB Copayment

<b>Workers' Compensation Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i></b>
This Segment is always sent		
This Segment is situational	X	This segment is not required.

	<b>Workers' Compensation Segment Segment Identification (111-AM) = "Ø6"</b>			<b>Claim Billing/Claim Rebill</b>
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Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
434-DY	DATE OF INJURY		RW	Not Required
315-CF	EMPLOYER NAME		RW	Not Required
316-CG	EMPLOYER STREET ADDRESS		RW	Not Required
317-CH	EMPLOYER CITY ADDRESS		RW	Not Required
318-CI	EMPLOYER STATE/PROVINCE ADDRESS		RW	Not Required
319-CJ	EMPLOYER ZIP/POSTAL ZONE		RW	Not Required
320-CK	EMPLOYER PHONE NUMBER		RW	Not Required
321-CL	EMPLOYER CONTACT NAME		RW	Not Required
327-CR	CARRIER ID		RW	Not Required
435-DZ	CLAIM/REFERENCE ID		RW	Not Required
117-TR	BILLING ENTITY TYPE INDICATOR		RW	Not Required
118-TS	PAY TO QUALIFIER		RW	Not Required
119-TT	PAY TO ID		RW	Not Required
120-TU	PAY TO NAME		RW	Not Required
121-TV	PAY TO STREET ADDRESS		RW	Not Required
122-TW	PAY TO CITY ADDRESS		RW	Not Required
123-TX	PAY TO STATE/PROVINCE ADDRESS		RW	Not Required
124-TY	PAY TO ZIP/POSTAL ZONE		RW	Not Required
125-TZ	GENERIC EQUIVALENT PRODUCT ID QUALIFIER		RW	Not Required
126-UA	GENERIC EQUIVALENT PRODUCT ID		RW	Not Required

DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	This segment is not required.

DUR/PPS Segment Segment Identification (111-AM) = "08"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	Required if segment is used
439-E4	REASON FOR SERVICE CODE		RW	Required if segment is used
440-E5	PROFESSIONAL SERVICE CODE		RW	Required if segment is used
441-E6	RESULT OF SERVICE CODE		RW	Required if segment is used
474-8E	DUR/PPS LEVEL OF EFFORT		RW	Required if segment is used
475-J9	DUR CO-AGENT ID QUALIFIER		RW	Required if 476-H6 is used. Values 01, 02, 03, 20.
476-H6	DUR CO-AGENT ID		RW	Encouraged if code DC, DD, ID, MC, TD in 439-E4.

Coupon Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required in B1 and B3 transactions ONLY if Coupons apply to the Claim. Not required for B2 transactions.

Coupon Segment Segment Identification (111-AM) = "09"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
485-KE	COUPON TYPE		M	Required if segment is used
486-ME	COUPON NUMBER		M	Required if segment is used
487-NE	COUPON VALUE AMOUNT		M	Required if segment is used



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Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	<b>This segment is required when submitting a claim for Multi Ingredient Claim Transaction (Compound Code = 02).</b>

Field #	Compound Segment Segment Identification (111-AM) = "10"	Value	Payer Usage	Claim Billing/Claim Rebill Payer Situation
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
452-EH	COMPOUND ROUTE OF ADMINISTRATION		M	Required when submitting compound claims.
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER		M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		R	Required if needed for receiver claim determination when multiple products are billed.
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION		R	Required if needed for receiver claim determination when multiple products are billed.

Clinical Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	This segment is not required.

Field #	Clinical Segment Segment Identification (111-AM) = "13"	Value	Payer Usage	Claim Billing/Claim Rebill Payer Situation
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	Not Required
492-WE	DIAGNOSIS CODE QUALIFIER		RW	Not Required
424-DO	DIAGNOSIS CODE		RW	Not Required
493-XE	CLINICAL INFORMATION COUNTER	Maximum 5 occurrences supported.	RW	Not Required
494-ZE	MEASUREMENT DATE		RW	Not Required
495-H1	MEASUREMENT TIME		RW	Not Required
496-H2	MEASUREMENT DIMENSION		RW	Not Required
497-H3	MEASUREMENT UNIT		RW	Not Required
499-H4	MEASUREMENT VALUE		RW	Not Required

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

#### GENERAL INFORMATION

Payer Name: <a href="#">MaxCare Prescription Benefit Services</a>	Date: 06/01/2011
Plan Name/Group Name: ALL	BIN: 610170 PCN: MRX

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

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



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

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

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent		
This Segment is situational	X	Provided when additional message text is necessary

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) <i>Payer Situation</i>
504-F4	MESSAGE		RW	Required if text is needed for clarification or detail.

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

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) <i>Payer Situation</i>
301-C1	GROUP ID		R	Required if needed for pharmacy claim processing and payment
545-2F	NETWORK REIMBURSEMENT ID		RW	Not Required
568-J7	PAYER ID QUALIFIER		RW	Required if Payer ID (569-J8) is used.
569-J8	PAYER ID		RW	Not Required
302-C2	CARDHOLDER ID			Member's ID as shown on card. Required

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

Field #	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid) <i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
503-F3	AUTHORIZATION NUMBER		R	Required if needed to identify the transaction.
547-5F	APPROVED MESSAGE CODE COUNT	Maximum count of 5.	RW	Required if Approved Message Code (548-6F) is used.



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	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
548-6F	APPROVED MESSAGE CODE		RW	Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow up for a potential opportunity.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	Required if Help Desk Phone Number (550-8F) is used.
550-8F	HELP DESK PHONE NUMBER		RW	Required if needed to provide a support telephone number to the receiver.

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

	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
551-9F	PREFERRED PRODUCT COUNT	Maximum count of 6.	RW	Required if Preferred Product ID (553-AR) is used. Based on benefit and when preferred alternative are available for the submitted product service ID.
552-AP	PREFERRED PRODUCT ID QUALIFIER		RW	Required if Preferred Product ID (553-AR) is used.
553-AR	PREFERRED PRODUCT ID		RW	Required if a product preference exists that needs to be communicated to the receiver via an ID.
556-AU	PREFERRED PRODUCT DESCRIPTION		RW	Required if a product preference exists that either cannot be communicated by the Preferred Product ID (553-AR) or to clarify the Preferred Product ID (553-AR).

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

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
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## MaxCare Prescription Benefit Services Payer Specification Sheet

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID		R	Required if this value is used to arrive at the final reimbursement.
557-AV	TAX EXEMPT INDICATOR		RW	Required if the sender (health plan) and/or patient are tax exempt and exemption applies to this billing.
558-AW	FLAT SALES TAX AMOUNT PAID		RW	Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (Ø) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement.
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		RW	Required if this value is used to arrive at the final reimbursement.  Required if Percentage Sales Tax Amount Submitted (482-GE) is greater than zero (Ø).  Required if Percentage Sales Tax Rate Paid (560-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used.
560-AY	PERCENTAGE SALES TAX RATE PAID		RW	Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).
561-AZ	PERCENTAGE SALES TAX BASIS PAID		RW	Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).
521-FL	INCENTIVE AMOUNT PAID		RW	Required if this value is used to arrive at the final reimbursement.  Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø).
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	RW	Required if Other Amount Paid (565-J4) is used.
564-J3	OTHER AMOUNT PAID QUALIFIER		RW	Required if Other Amount Paid (565-J4) is used.
565-J4	OTHER AMOUNT PAID		RW	Required if this value is used to arrive at the final reimbursement.  Required if Other Amount Claimed Submitted (480-H9) is greater than zero (Ø).
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	Required if this value is used to arrive at the final reimbursement.  Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.
509-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		R	Required if Ingredient Cost Paid (506-F6) is greater than zero (Ø).  Required if Basis of Cost Determination (432-DN) is submitted on billing.
523-FN	AMOUNT ATTRIBUTED TO SALES TAX		RW	Required if Patient Pay Amount (505-F5) includes sales tax that is the financial responsibility of the member but is not also included in any of the other fields that add up to Patient Pay Amount.
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT		RW	Provided for informational purposes only.
513-FD	REMAINING DEDUCTIBLE AMOUNT		RW	Provided for informational purposes only.
514-FE	REMAINING BENEFIT AMOUNT		RW	Provided for informational purposes only.
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	Required if Patient Pay Amount (505-F5) includes deductible
518-FI	AMOUNT OF COPAY		RW	Required if Patient Pay Amount (505-F5) includes copay as patient financial responsibility.



## MaxCare Prescription Benefit Services Payer Specification Sheet

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
52Ø-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		RW	Required if Patient Pay Amount (5Ø5-F5) includes amount exceeding periodic benefit maximum.
346-HH	BASIS OF CALCULATION—DISPENSING FEE		RW	Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill).
347-HJ	BASIS OF CALCULATION—COPAY		RW	Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill).
348-HK	BASIS OF CALCULATION—FLAT SALES TAX		RW	Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill) and Flat Sales Tax Amount Paid (558-AW) is greater than zero (Ø).
349-HM	BASIS OF CALCULATION—PERCENTAGE SALES TAX		RW	Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill) and Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø).
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE		RW	Required if the customer is responsible for 1ØØ% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay.
575-EQ	PATIENT SALES TAX AMOUNT		RW	Used when necessary to identify the Patient's portion of the Sales Tax. Provided for informational purposes only.
574-2Y	PLAN SALES TAX AMOUNT		RW	Used when necessary to identify the Plan's portion of the Sales Tax. Provided for informational purposes only.
572-4U	AMOUNT OF COINSURANCE		RW	Required if Patient Pay Amount (5Ø5-F5) includes coinsurance as patient financial responsibility.
573-4V	BASIS OF CALCULATION-COINSURANCE		RW	Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill).
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	RW	Required if Benefit Stage Amount (394-MW) is used.
393-MV	BENEFIT STAGE QUALIFIER		RW	Required if Benefit Stage Amount (394-MW) is used.
394-MW	BENEFIT STAGE AMOUNT		RW	Required when a Medicare Part D payer applies financial amounts to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts.  Required if necessary for state/federal/regulatory agency programs.
577-G3	ESTIMATED GENERIC SAVINGS		RW	This information should be provided when a patient selected the brand drug and a generic form of the drug was available. It will contain an estimate of the difference between the cost of the brand drug and the generic drug, when the brand drug is more expensive than the generic.
128-UC	SPENDING ACCOUNT AMOUNT REMAINING		RW	This dollar amount will be provided, if known, to the receiver when the transaction had spending account dollars reported as part of the patient pay amount.



## MaxCare Prescription Benefit Services Payer Specification Sheet

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT		RW	Required when the patient meets the plan-funded assistance criteria, to reduce Patient Pay Amount (505-F5). The resulting Patient Pay Amount (505-F5) must be greater than or equal to zero.
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION		RW	Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG		RW	Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a Brand drug.
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION		RW	Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a non-preferred formulary product.
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION		RW	Required if Patient Pay Amount (505-F5) includes an amount that is attributable to a patient's selection of a Brand non-preferred formulary product.
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP		RW	Required when the patient's financial responsibility is due to the coverage gap.
148-U8	INGREDIENT COST CONTRACTED/REIMBURSABLE AMOUNT		RW	Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency.
149-U9	DISPENSING FEE CONTRACTED/REIMBURSABLE AMOUNT		RW	Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency.

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