



# Companion Guide – NCPDP Versions 1.1 and 5.1 Transaction Payer Sheet

LIBRARY REFERENCE NUMBER: PRPH10013  
REVISION DATE: OCTOBER 2008  
VERSION 3.2

Library Reference Number: PRPH10013

Document Management System Reference: Companion Guide - NCPDP Versions 1.1 and 5.1  
Transaction Payer Sheet (17931)

Address any comments concerning the contents of this manual to:

EDS Pharmacy Unit  
950 North Meridian Street, Suite 1150  
Indianapolis, IN 46204  
Fax: (317) 488-5169

*EDS and the EDS logo are registered trademarks of Hewlett-Packard Development Company, LP.  
HP is an equal opportunity employer and values the diversity of its people.  
© 2008 Hewlett-Packard Development Company, LP.*

*Current Dental Terminology (CDT) (including procedures codes, nomenclature, descriptors, and other data contained therein) is copyrighted by the American Dental Association. ©2007, 2008 American Dental Association. All rights reserved. Applicable Federal Acquisition Regulation System/Department of Defense Acquisition Regulation System (FARS/DFARS) Apply.*

*Current Procedural Terminology (CPT) is copyright 2008 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply for government use.*

*NCPDP is a registered trademark of the ©National Council for Prescription Drug Programs, Inc. 1988, 1992 NCPDP. Versions 5.1 and its predecessors include proprietary material that is protected under the U.S. Copyright Law, and all rights remain with NCPDP*

## ***Revision History***

<b>Document Version Number</b>	<b>CO</b>	<b>Revision Date</b>	<b>Revision Page Number(s)</b>	<b>Reason for Revisions</b>	<b>Revisions Completed By</b>
Version 1.0		December 2004	All	New document	Systems/Publications
Version 2.0		March 2005	3-7	Added 430-DU field information	Systems/Publications
Version 3.0		April 2008		Updated for NPI	Pharmacy/Publications
Version 3.1		October 2008			Pharmacy/Publications
Version 3.2		October 2008	Table 3.4		Pharmacy/Publications



## Table of Contents

---

<b>Section 1: Introduction.....</b>	<b>1-1</b>
Overview .....	1-1
<b>Section 2: NCPDP Version 5.1 Transaction Set Information .....</b>	<b>2-1</b>
General Transaction Formatting Information.....	2-1
Variable Usage Guidelines.....	2-2
The Overpunch Sign.....	2-2
Implied Decimal Points.....	2-3
Truncation.....	2-3
<b>Section 3: NCPDP Version 5.1 Transaction .....</b>	<b>3-1</b>
Billing/Rebill Claim Request (B1/B3) .....	3-1
Claim Reversal .....	3-11
<b>Section 4: NCPDP Version 5.1 Responses .....</b>	<b>4-1</b>
Billing/Rebill Paid Response.....	4-1
Billing/Rebill Reject Response.....	4-4
Reversal Approved Response.....	4-7
Reversal Rejected Response.....	4-9
Transmission Rejected; Transaction Rejected Response .....	4-11
<b>Section 5: NCPDP Version 1.1 Batch Transaction .....</b>	<b>5-1</b>
<b>Index .....</b>	<b>I-1</b>



## Section 1: Introduction

---

### Overview

*Materials Reproduced with the Consent of<sup>®</sup> National Council for Prescription Drug Programs, Inc. 1988, 1992 NCPDP*

NCPDP is a registered trademark of the National Council for Prescription Drug Programs (NCPDP), Inc., Versions 1.1 and 5.1, and their predecessors include proprietary material that is protected under the U.S. Copyright Law, and all rights remain with NCPDP.

- NCPDP Version 1.1 defines the data structure and content of batch pharmacy transmissions only.
- NCPDP Version 5.1 defines the data structure and content of single place of service (POS) transmissions only.

These specifications cover the minimum required fields (mandatory) per the NCPDP Versions 1.1 and 5.1 standards as well as the required fields needed for the Indiana Health Coverage Programs (IHCP) claims processing.

Standard common business-oriented language (COBOL) documentation is used for transaction descriptions. The following definitions are given to ensure consistency of interpretation:

- **Field** – The NCPDP data element identifier for a given transaction.
- **Field Name** – The short definition, name, or literal constant of the data located within the transaction at the positions indicated.
- **Field Format** – The COBOL PICTURE (PIC) clause that describes how the data is presented on the transmission.
  - X = An alphanumeric character
  - 9 = A numeric character
  - S = A numeric value sign (+ or -)
  - V = An implied decimal point
  - ( ) = The character if front of the left parenthesis is repeated the number of times between the parentheses; for example, X(5) represents the same picture as XXXXX.
- **Type** – The type of data used in the field.
  - A - Alphanumeric – Always left justified and space filled; A-Z, 0-9, and printable characters
  - D - Signed Numeric – Always right-justified, zero always positive, zero filled dollar-cents amount with two positions to the right of the implied decimal point, all other positions to the left of the implied decimal point, and have default values of zeros when used for dollar fields. Sign is internal and trailing.  
*Example: D field of length 8 is represented \$\$\$\$\$\$cc*
  - N - Unsigned Numeric – Always right-justified and zero filled.  
*Example: 9(7)V999 is represented as 9999999.999*
- **Value** – If a particular value is expected for the IHCP system, that value is given.
- **Comments** – This portion indicates if a field is required.
  - Mandatory fields are required by the NCPDP Versions 1.1 or 5.1 standard
  - Required fields are necessary for claim adjudication by the processor (EDS)

- Optional fields are accepted and are typically used for claim adjudication
- Required when known/situational fields will be accepted and may be used for claim adjudication

The NCPDP Version 1.1 Header and Trailer records are in a **fixed-format** standard. Therefore, all of these segments and fields are required. The Detail Data Record is in a **variable-format** standard, with the exception of the Header Segment. Use the IHCP Version 5.1 Payer Sheet for the Detail Data Record instructions.

The NCPDP Version 5.1 transaction is a **variable length format** standard. Therefore, with the exception of the header fields (which are always required), a transaction will contain only those elements that are necessary.

Even though a segment or field may not be covered in this document, it does not mean the segment or field cannot be sent. All records, segments, and fields that are allowed for NCPDP Versions 1.1 and 5.1 are accepted by the IHCP. Only those segments and fields pertinent to claims processing are used in the IndianaAIM claims processing system. Refer to the *NCPDP Batch Transaction Standard Implementation Guide Version 1 Release 1* and the *NCPDP Telecommunication Standard Implementation Guide Version 5 Release 1* for further information about the various segments and fields allowed.

This payer sheet is divided into the following sections:

- *Section 1: Introduction*
- *Section 2: NCPDP Version 5.1 Transaction Set Information*
- *Section 3: NCPDP Version 5.1 Transaction*
- *Section 4: NCPDP Version 5.1 Responses*
- *Section 5: NCPDP Version 1.1 Batch Transaction*

## Section 2: NCPDP Version 5.1 Transaction Set Information

---

### General Transaction Formatting Information

The first segment of every transmission (request or response) is the Header Segment. This is the only segment that does not have a Segment Identification because it is a fixed field and length segment. After the Header Segment, other segments are included, according to the particular transaction type. Every other segment has an identifier to denote the particular segment for parsing. Segments may appear in any order after the Header Segment, according to whether the segment occurs at the transmission or transaction level. Segments are not allowed to repeat within a transaction. Segments may occur more than once only in a multi-transaction transmission.

In the Header Segment, all fields are required positionally and filled to their maximum designation. This is a fixed segment. If a mandatory field is not used, it must be filled with spaces or zeroes, as appropriate. The fields within the Header Segment do not use field separators.

Other segments may have both mandatory and required fields. Required fields in a segment are submitted after the mandatory fields. A field separator and the field's identifier must precede both types of fields. Required fields may appear in any order except for those designated with a qualifier or in a repeating group. The mandatory and required fields may be truncated to the actual size used.

Parsing is accomplished with the use of separators. Version 5.1 uses the following three separators:

- Segment separator                      Hex 1E (Dec 30)
- Group separator                         Hex 1D (Dec 29)
- Field separator                         Hex 1C (Dec 28)

A transmission consists of one or more transactions separated by group separators. All transmissions, whether for one, two, three, or four transactions, use group separators to denote the start of a transaction.

Within a transaction, appropriate segments are included. Segments are delineated with the use of Segment separators. Segments are also identified with the use of a Segment Identification in the first position of each segment. One or many segments may be included in each transaction. Field separators are used to delineate fields in the segments.

The general syntax of a transmission request and response appears as follows:

Table 2.1 – Syntax of Transmission Request and Response

Header Segment	
	Header Segment Fields
Segment Separator	
	Required Fields within Segment as appropriate, with field separators
	Optional Segment Fields with field separators
Segment Separator	
	Required Fields within Segment as appropriate, with field separators
	Optional Segment Fields with field separators
Group Separator	
Segment Separator	
	Required Fields within Segment as appropriate, with field separators
	Optional Segment Fields with field separators
Segment Separator	
	Required Fields within Segment as appropriate, with field separators
	Optional Segment Fields with field separators

### Variable Usage Guidelines

The following variable usage guidelines apply to Version 5.1:

- Version 5.1 allows variable length transactions only.
- Version 5.1 supports up to four transactions per transmission for transaction codes B1, B2, and B3. Compound billing transactions (B1, B2, and B3) may only contain one transaction.
- Leading zeros and trailing blanks may be omitted from some data fields.
- Alphanumeric fields default to spaces, not null characters, when empty.
- Numeric fields default to zeroes.
- Dollar fields default to zeroes; however, dollar fields are always signed. The least significant digit of a dollar field must always be an Overpunch Sign, not a digit.

### The Overpunch Sign

The purpose of using Overpunch signs in dollar fields is to allow the representation of positive and negative dollar amounts without expanding the size of the field (for example, to hold the plus or minus character).

The Overpunch sign replaces the right most character in a dollar field. The signed value designates the positive or negative status of the numeric value. The dollar field of \$99.95 would be represented as 999E with truncation. A negative dollar amount of \$2.50 would be represented as 25} with truncation. The following information is used for Version 5.1.

Table 2.2 – Overpunch Sign

Unit	Signed Positive				Signed Negative			
	Graphic	Oct	Dec	Hex	Graphic	Oct	Dec	Hex
0	{	173	123	7B	}	175	125	7D
1	A	101	65	41	J	112	74	4A
2	B	102	66	42	K	113	75	4B
3	C	103	67	43	L	114	76	4C
4	D	104	68	44	M	115	77	4D
5	E	105	69	45	N	116	78	4E
6	F	106	70	46	O	117	79	4F
7	G	107	71	47	P	1250	80	50
8	H	110	72	48	Q	121	81	51
9	I	111	73	49	R	122	82	52

*Table values show ASCII values.*

### Implied Decimal Points

In the Version 5.1 standard, only patient clinical value fields contain decimal points. All other decimal points are implied. For example, patient diagnosis codes must be formatted with explicit decimal points.

*Note: Decimal points in dollar fields are implied.*

### Truncation

To truncate a field using Version 5.1 format perform the following steps:

1. Numeric (N or D): Remove leading zeros
2. Alphanumeric (A): Remove trailing spaces

*Do not truncate or eliminate any fields in the required header segments.*



## Section 3: NCPDP Version 5.1 Transaction

---

### Billing/Rebill Claim Request (B1/B3)

Table 3.1 – Transaction Header Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
101-A1	BIN Number	9(6)	N	<b>610467</b> – IN Medicaid	Mandatory
102-A2	Version/Release Number	x(2)	A	<b>51</b> – Version 5.1	Mandatory
103-A3	Transaction Code	x(2)	A	<b>B1</b> – Billing <b>B3</b> – Rebill	Mandatory
104-A4	Processor Control Number	x(10)	A	<b>INCAIDPROD</b> – production <b>INCAIDTEST</b> – test	Mandatory
109-A9	Transaction Count	x(1)	A	<b>1</b> – One occurrence <b>2</b> – Two occurrences <b>3</b> – Three occurrences <b>y</b> – Four occurrences Maximum of one allowed for compound transactions	Mandatory
202-B2	Service Provider ID Qualifier	x(2)	A	<b>01-National Provider Identifier (NPI)</b>	Mandatory
201-B1	Service Provider ID	x(15)	A	Billing provider’s 10-digit NPI	Mandatory
401-D1	Date of Service	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Mandatory
110-AK	Software Vendor/Certification ID	x(10)	A		Required when known

Table 3.2 – Patient Segment: Required

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>01</b> – Patient	Mandatory when segment is present
310-CA	Patient First Name	x(12)	A	Patient first name	Required
311-CB	Patient Last Name	x(15)	A	Patient last name	Required
307-C7	Patient Location	9(2)	N	<b>00</b> – Not specified <b>03</b> – Nursing home <b>04</b> – Long term/extended care <b>11</b> – Hospice	Required when known <b>04</b> is to be used for a member who resides in an intermediate care facility for the mentally retarded (ICF/MR)
335-2C	Pregnancy Indicator	x(1)	A	<b>2</b> – Pregnant	Required when known

Table 3.3 – Insurance Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>04</b> – Insurance	Mandatory
302-C2	Cardholder ID	x(20)	A	12-digit Indiana Medicaid member ID number	Mandatory
301-C1	Group ID	x(15)	A	For fee for service claims: <b>INCAID100</b> For managed care organization (MCO) encounter claims: 10-character MCO ID (nine-digit MCO ID plus one alpha character region code)	Required

Table 3.4 – Claim Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>07</b> – Claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	x(1)	A	<b>1</b> – Rx billing	Mandatory
402-D2	Prescription/Service Reference Number	9(7)	N	Prescription number	Mandatory
436-E1	Product/Service ID Qualifier	x(2)	A	<b>00</b> – Not specified <b>03</b> – National Drug Code (NDC)	Mandatory Compound: Use <b>00</b> to designate multi-ingredient product.
407-D7	Product/Service ID	x(19)	A	NDC (Drug Code) 11 characters	Mandatory
442-E7	Quantity Dispensed	9(7).9(3)	D	Maximum of 9999999.999	Required Enter the 10-digit metric decimal quantity of the drug dispensed. Compound: Enter the quantity of entire multi-ingredient product.
403-D3	Fill Number	9(2)	N	<b>00</b> – Original dispensing <b>01–99</b> – Refill number	Required
405-D5	Days Supply	9(3)	N	Estimated number of days the prescription will last	Required
406-D6	Compound Code	9(1)	N	<b>1</b> – Not a compound <b>2</b> – Compound	Required
408-D8	Dispense as Written Code (DAW)/Product Selection Code	x(1)	A	<b>0</b> – No product selection indicated <b>5</b> – Substitution allowed-brand drug dispensed as a generic <b>6</b> – Override <b>8</b> – Substitution allowed-generic drug not available in marketplace	Code indicating the prescriber's instructions regarding substitution DAW 6 is required when prescriber has written <i>Brand Medically Necessary</i> on the prescription. This may also require PA.

Field	Field Name	Field Format	Type	Value	Comments
					DAW 6 is also used when billing for a multi-source <b>brand</b> name drug that is preferred over its generic equivalent on the Indiana Medicaid Preferred Drug List. Other values sent treated as 0
414-DE	Date Prescription Written	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Required
420-DK	Submission Clarification Code	9(2)	N	<b>08</b> – Process compound for approved ingredients	Situational
308-C8	Other Coverage Code	9(2)	N	<b>02</b> – Other coverage exists – payment collected <b>03</b> – Other coverage exists – claim not covered <b>04</b> – Other coverage exists – payment not collected <b>05</b> – Managed care plan denial <b>06</b> – Other coverage denied – not participating provider <b>07</b> – Other coverage exists – not in effect on DOS <b>08</b> – Claim is billing for copay	Situational
418-DI	Level of Service	9(2)	N	<b>00</b> – Not specified <b>03</b> – Emergency	Required when known

Table 3.5 – Prescriber Segment: Required

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>03</b> – Prescriber	Mandatory
466-EZ	Prescriber ID Qualifier	x(2)	A	<b>01-National Prescriber Identifier (NPI)</b>	Required
411-DB	Prescriber ID	x(15)	A	Ten-digit national provider identifier of the prescribing practitioner.	Required

Table 3.6 – Coordination of Benefits (COB) and Other Payments Segment: Optional

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>05</b> – Coordination of benefits/other payments	Mandatory when segment is present
337-4C	Coordination of Benefits/Other Payments Count	9(1)	N	<b>1 - 9</b> Maximum of nine allowed	Mandatory when segment is present. National Council for Prescription Drug Programs (NCPDP) recommends limiting the number of payers to three in the COB segment.
338-5C	Other Payer Coverage Type	x(2)	A	Blank – Not specified <b>01</b> – Primary <b>02</b> – Secondary <b>03</b> – Tertiary <b>99</b> – Composite	Mandatory when segment is present (Repeating)
443-E8	Other Payer Date	9(8)		CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Required when known (Repeating)
341-HB	Other Payer Amount Paid Count	9(1)	N	<b>1 – 9</b> Maximum of nine allowed	Required when known

Field	Field Name	Field Format	Type	Value	Comments
342-HC	Other Payer Amount Paid Qualifier	x(2)	A	Blank – Not specified <b>07</b> – Drug benefit <b>08</b> – Sum of all reimbursement <b>99</b> – Other	Required when known (Repeating)
431-DV	Other Payer Amount Paid	s9(6).9(2)	D	s\$\$\$\$\$cc s9(6)v99	Required when there is payment from another source (Repeating)

Table 3.7 – Drug Utilization Review/Prospective Payment System (DUR/PPS) Segment:  
Optional

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>8</b> - DUR/PPS	Mandatory when segment is present
473-7E	DUR/PPS Code Counter	9(1)	N	<b>1</b>	Required when known Maximum of one allowed
439-E4	Reason for Service Code	x(2)	A	<b>DD</b> – Drug/Drug Interaction <b>ER</b> – Early Refill <b>HD</b> – High Dose <b>LD</b> – Low Dose <b>LR</b> – Late Refill <b>MC</b> – Drug/Disease (Reported) <b>PA</b> – Drug/Age <b>PG</b> – Drug/Pregnancy <b>TD</b> – Therapeutic	Required when known In the case of multiple <i>Reason for Service</i> Codes, only the last code is processed
440-E5	Professional Service Code	x(2)	A	<b>00</b> – No intervention <b>M0</b> – Prescriber consulted <b>P0</b> – Patient consulted <b>R0</b> – Pharmacist consulted other source	Required when known Example: If the pharmacist spoke with the patient as a result of a conflict code being transmitted on a prescription, the field would reflect <b>P0</b> .

Field	Field Name	Field Format	Type	Value	Comments
441-E6	Result of Service Code	x(2)	A	<b>1A</b> – Filled as is, false positive <b>1B</b> – Filled prescription as is <b>1C</b> – Filled, with different dose <b>1D</b> – Filled, with different directions <b>1E</b> – Filled, with different drug <b>1F</b> – Filled, with different quantity <b>1G</b> – Filled, with prescriber approval <b>2A</b> – Prescription not filled <b>2B</b> – Not filled, directions clarified	Required when known

Table 3.8 – Pricing Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>11</b> – Pricing	Mandatory
426-DQ	Usual and Customary Charge	s9(6).9(2)	D	s\$\$\$\$\$cc s9(6)v99	Required Total amount billed
430-DU	Gross Amount Due	9(9)v99b or 9(9)v99-	D	s\$\$\$\$\$cc s9(6)v99	Required when submitting claim with Other Coverage Code 8 in field 308-C8 (billing for third party liability (TPL) copay only)

Field	Field Name	Field Format	Type	Value	Comments
480-H9	Other Amount Claimed Submitted	s9(6)v99	D	\$\$\$\$\$\$cc S9(6)v99	Required when submitting claim with Other Coverage Code 8 in field 308-C8 (billing for third party liability (TPL) copay only). Must be equal to Gross Amount Due in field 430-DU
479-HB	Other Amount Claimed Submitted Qualifier	x(2)	N	99 - Other	Required when submitting claim with Other Coverage Code 8 in field 308-C8 (billing for third party liability (TPL) copay only).

Table 3.9 – Compound Segment: Optional

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	10 – Compound	Mandatory when segment is present Field 406-D6 in the Claim Segment must = 2

Field	Field Name	Field Format	Type	Value	Comments
450-EF	Compound Dosage Form Description Code	x(2)	A	<b>Blank</b> – Not Specified <b>01</b> – Capsule <b>02</b> – Ointment <b>03</b> – Cream <b>04</b> – Suppository <b>05</b> – Powder <b>06</b> – Emulsion <b>07</b> – Liquid <b>10</b> – Tablet <b>11</b> – Solution <b>12</b> – Suspension <b>13</b> – Lotion <b>14</b> – Shampoo <b>15</b> – Elixir <b>16</b> – Syrup <b>17</b> – Lozenge <b>18</b> – Enema	Mandatory when segment is present
451-EG	Compound Dispensing Unit Form Indicator	9(1)	N	<b>1</b> – Each <b>2</b> – Grams <b>3</b> – Milliliters	Mandatory when segment is present
452-EH	Compound Route of Administration	9(2)	N	<b>0</b> – Not Specified <b>1</b> – Buccal <b>2</b> – Dental <b>3</b> – Inhalation <b>4</b> – Injection <b>5</b> – Intraperitoneal <b>6</b> – Irrigation <b>7</b> – Mouth/Throat <b>8</b> – Mucous Membrane <b>9</b> – Nasal <b>10</b> – Ophthalmic <b>11</b> – Oral <b>12</b> – Other/Miscellaneous <b>13</b> – Otic <b>14</b> – Perfusion <b>15</b> – Rectal <b>16</b> – Sublingual <b>17</b> – Topical	Mandatory when segment is present

Field	Field Name	Field Format	Type	Value	Comments
				<b>18</b> – Transdermal <b>19</b> – Translingual <b>20</b> – Urethral <b>21</b> – Vaginal <b>22</b> – Enteral	
447-EC	Compound Ingredient Component Count	9(2)	N	<b>01 – 40</b>	Mandatory when segment is present
488-RE	Compound Product ID Qualifier	x(2)	A	<b>03</b> – NDC Code	Mandatory when segment is present (Repeating)
489-TE	Compound Product ID	X(19)	A	NDC (Drug Code) 11 characters	Mandatory when segment is present (Repeating)
448-ED	Compound Ingredient Quantity	9(7).9(3)	D	Compound Ingredient Quantity 9999999.999	Mandatory when segment is present (Repeating)

Table 3.10 – Clinical Segment: Optional

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>13</b> – Clinical	Mandatory when segment present
491-VE	Diagnosis Code Count	9(1)	N	<b>1</b> Max of 1 allowed	Required when known
492-WE	Diagnosis Code Qualifier	x(2)	A	<b>01</b> – International Classification of Diseases (ICD-9)	Required when known
424-DO	Diagnosis Code	x(15)	A	Three to seven-digit alphanumeric code. One occurrence allowed.	Required when known

## Claim Reversal

Table 3.11 – Transaction Header Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
101-A1	BIN Number	9(6)	N	<b>610467</b> – IN Medicaid	Mandatory
102-A2	Version/Release Number	x(2)	A	<b>51</b> – Version 5.1	Mandatory
103-A3	Transaction Code	x(2)	A	<b>B2</b> – Reversal	Mandatory
104-A4	Processor Control Number	x(10)	A	<b>INCAIDPROD</b> – production <b>INCAIDTEST</b> – test	Mandatory
109-A9	Transaction Count	x(1)	A	<b>1</b> – One occurrence <b>2</b> – Two occurrences <b>3</b> – Three occurrences <b>4</b> – Four occurrences	Mandatory
202-B2	Service Provider ID Qualifier	x(2)	A	<b>05</b> – Medicaid	Mandatory <i>Note: This qualifier does not guarantee IHCP enrollment, unless the provider is currently enrolled.</i>
201-B1	Service Provider ID	x(15)	A	10-character billing pharmacy provider ID number assigned by IHCP (nine-digit provider number plus one alpha character location code)	Mandatory <i>Note: If the service provider is also enrolled in IHCP, this is the <b>same</b> provider number.</i>
401-D1	Date of Service	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Mandatory
110-AK	Software Vendor/Certification ID	x(10)	A	Spaces	Mandatory

Table 3.12 – Claim Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>07</b> – Claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	x(1)	A	<b>1</b> – Rx billing	Mandatory
402-D2	Prescription/Service Reference Number	9(7)	N	Prescription number	Mandatory
436-E1	Product/Service ID Qualifier	x(2)	A	<b>03</b> – National Drug Code (NDC)	Mandatory
407-D7	Product/Service ID	x(19)	A	NDC (Drug Code) 11 characters	Mandatory

## Section 4: NCPDP Version 5.1 Responses

---

### Billing/Rebill Paid Response

Table 4.1 – Response Header Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
102-A2	Version/Release Number	x(2)	A	<b>51</b> – Version 5.1	Mandatory
103-A3	Transaction Code	x(2)	A	<b>B1</b> – Billing <b>B3</b> – Rebill	Mandatory
109-A9	Transaction Count	x(1)	A	<b>1</b> – One occurrence <b>2</b> – Two occurrences <b>3</b> – Three occurrences <b>4</b> – Four occurrences	Mandatory
501-F1	Header Response Status	x(1)	A	<b>A</b> – Accepted	Mandatory
202-B2	Service Provider ID Qualifier	x(2)	A	<b>05</b> – Medicaid	Mandatory <i>Note: This qualifier does not guarantee Indiana Health Coverage Programs (IHCP) enrollment, unless the provider is currently enrolled.</i>
201-B1	Service Provider ID	x(15)	A	Provider ID is returned from the ID received on the request	Mandatory <i>Note: If the service provider is also enrolled in IHCP, this is the <b>same</b> provider number.</i>
401-D1	Date of Service	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Mandatory

Table 4.2 – Response Message Segment: Optional

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>20</b> – Response message	Mandatory when segment is present
504-F4	Message	x(200)	A	This field contains response-specific text	Required if additional message is needed

Table 4.3 – Response Status Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>21</b> – Response status	Mandatory
112-AN	Transaction Response Status	x(1)	A	<b>P</b> – Paid <b>D</b> – Duplicate of paid	Mandatory
503-F3	Authorization Number	x(20)	A	13-character Internal Control Number (ICN) for original claim	Required
526-FQ	Additional Message Information	x(200)	A	This field contains response-specific text	Required if additional message is needed

Table 4.4 – Response Claim Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>22</b> – Response claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	x(1)	A	<b>1</b> – Rx billing	Mandatory
402-D2	Prescription/Service Reference Number	9(7)	N	Prescription number	Mandatory

Table 4.5 – Response Pricing Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>23</b> – Response pricing	Mandatory
505-F5	Patient Pay Amount	s9(6).9(2)	D	s\$\$\$\$\$cc s9(6)v99	Required
507-F7	Dispensing Fee Paid	s9(6).9(2) s9(6)V99	D	s\$\$\$\$\$cc s9(6)v99	Required

Field	Field Name	Field Format	Type	Value	Comments
509-F9	Total Amount Paid	s9(6).9(2) s9(6)V99	D	s\$\$\$\$\$cc s9(6)v99	Required
518-FI	Amount of Copay/Co-insurance	s9(6).9(2) s9(6)V99	D	s\$\$\$\$\$cc s9(6)v99	Required

Table 4.6 – Response Drug Utilization Review/Prospective Payment System (DUR/PPS)  
Segment: Optional (Required if DUR information is sent in response)

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>24</b> – Response DUR/PPS	Mandatory when segment is present
567-J6	DUR/PPS Response Code Counter	9(1)	N	Counter number for each DUR/PPS response set/logical grouping.	Required when segment is present
439-E4	Reason for Service Code	x(2)	A	<b>DD</b> – Drug/Drug Interaction <b>ER</b> – Early Refill <b>HD</b> – High Dose <b>LD</b> – Low Dose <b>LR</b> – Late Refill <b>MC</b> – Drug/Disease (Reported) <b>PA</b> – Drug/Age <b>PG</b> – Drug/Pregnancy <b>TD</b> – Therapeutic	Required when segment is present
528-FS	Clinical Significance Code	x(1)	A	<b>Blank</b> – Not specified <b>1</b> – Major <b>2</b> – Moderate <b>3</b> – Minor	Required when appropriate
529-FT	Other Pharmacy Indicator	9(1)	N	<b>0</b> – Not specified <b>1</b> – Your pharmacy <b>2</b> – Other pharmacy in same chain <b>3</b> – Other pharmacy	Required when appropriate
530-FU	Previous Date of Fill	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Required when appropriate

Field	Field Name	Field Format	Type	Value	Comments
531-FV	Quantity of Previous Fill	s9(7).9(2)	N	9999999.999 9(7)V999	Required when appropriate
532-FW	Database Indicator	x(1)	A	1 – First Databank	Required when appropriate
533-FX	Other Prescriber Indicator	9(1)	N	0 – Not specified 1 – Same prescriber 2 – Other prescriber	Required when appropriate
544-FY	DUR Free Text Message	x(30)	A	This field contains DUR response-specific text	Required if additional message is needed

## Billing/Rebill Reject Response

Table 4.7 – Response Header Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
102-A2	Version/Release Number	x(2)	A	51 – Version 5.1	Mandatory
103-A3	Transaction Code	x(2)	A	B1 – Billing B3 – Rebill	Mandatory
109-A9	Transaction Count	x(1)	A	1 – One occurrence 2 – Two occurrences 3 – Three occurrences 4 – Four occurrences	Mandatory
501-F1	Header Response Status	x(1)	A	A – Accepted	Mandatory
202-B2	Service Provider ID Qualifier	x(2)	A	05 – Medicaid	Mandatory <i>Note: This qualifier does not guarantee IHCP enrollment, unless the provider is currently enrolled.</i>
201-B1	Service Provider ID	x(15)	A	Provider ID is returned from the ID received on the request	Mandatory <i>Note: If the service provider is also enrolled in IHCP, this is the same provider number.</i>

Field	Field Name	Field Format	Type	Value	Comments
401-D1	Date of Service	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Mandatory

Table 4.8 – Response Message Segment: Optional

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>20</b> – Response message	Mandatory when segment is present
504-F4	Message	x(200)	A	This field contains response-specific text	Required if additional message is needed

Table 4.9 – Response Status Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>21</b> – Response status	Mandatory
112-AN	Transaction Response Status	x(1)	A	<b>R</b> – Rejected	Mandatory
503-F3	Authorization Number	x(20)	A	13-character Internal Control Number (ICN) for original claim	Required
510-FA	Reject Count	9(2)	N	Reject count	Required
511-FB	Reject Code	x(3)	A	See <i>National Council on Prescription Drug Programs (NCPDP) Data Dictionary, Appendix F - Reject Codes</i>	Required
526-FQ	Additional Message Information	x(200)	A	This field contains response-specific text	Required if additional message is needed

Table 4.10 – Response Claim Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>22</b> – Response claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	x(1)	A	<b>1</b> – Rx billing	Mandatory
402-D2	Prescription/Service Reference Number	9(7)	N	Prescription number	Mandatory

Table 4.11 – Response DUR/PPS Segment: Optional (Required if DUR information is sent in response)

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>24</b> – Response DUR/PPS	Mandatory when segment is present
567-J6	DUR/PPS Response Code Counter	9(1)	N	Counter number for each DUR/PPS response set/logical grouping	Required when segment is present
439-E4	Reason for Service Code	x(2)	A	<b>DD</b> – Drug/Drug Interaction <b>ER</b> – Early Refill <b>HD</b> – High Dose <b>LD</b> – Low Dose <b>LR</b> – Late Refill <b>MC</b> – Drug/Disease (Reported) <b>PA</b> – Drug/Age <b>PG</b> – Drug/Pregnancy <b>TD</b> – Therapeutic	Required when known
528-FS	Clinical Significance Code	x(1)	A	<b>Blank</b> – Not specified <b>1</b> – Major <b>2</b> – Moderate <b>3</b> – Minor	Required when known
529-FT	Other Pharmacy Indicator	9(1)	N	<b>0</b> – Not specified <b>1</b> – Your pharmacy <b>2</b> – Other pharmacy in same chain <b>3</b> – Other pharmacy	Required when known

Field	Field Name	Field Format	Type	Value	Comments
530-FU	Previous Date of Fill	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Required when known
531-FV	Quantity of Previous Fill	s9(7).9(3)	D	9999999.999 9(7)V999	Required when known
532-FW	Database Indicator	x(1)	A	1 – First Databank	Required when known
533-FX	Other Prescriber Indicator	9(1)	N	0 – Not specified 1 – Same prescriber y – Other prescriber	Required when known
544-FY	DUR Free Text Message	x(30)	A	This field contains DUR response-specific text	Required if additional message is needed

## Reversal Approved Response

Table 4.12 – Response Header Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
102-A2	Version/Release Number	x(2)	A	51 – Version 5.1	Mandatory
103-A3	Transaction Code	x(2)	A	B2 – Reversal	Mandatory
109-A9	Transaction Count	x(1)	A	1 – One occurrence 2 – Two occurrences 3 – Three occurrences 4 – Four occurrences	Mandatory
501-F1	Header Response Status	x(1)	A	A – Accepted	Mandatory
202-B2	Service Provider ID Qualifier	x(2)	A	05 – Medicaid	Mandatory <i>Note: This qualifier does not guarantee IHCP enrollment, unless the provider is currently enrolled.</i>
201-B1	Service Provider ID	x(15)	A	Provider ID is returned from the ID received on the request	Mandatory <i>Note: If the service provider is also enrolled in IHCP, this is the same provider number.</i>

Field	Field Name	Field Format	Type	Value	Comments
401-D1	Date of Service	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Mandatory

Table 4.13 – Response Message Segment: Optional

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>20</b> – Response message	Mandatory
504-F4	Message	x(200)	A	This field contains response-specific text	Required if additional message is needed

Table 4.14 – Response Status Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>21</b> – Response status	Mandatory
112-AN	Transaction Response Status	x(1)	A	<b>A</b> – Approved	Mandatory
503-F3	Authorization Number	x(20)	A	13-character Internal Control Number (ICN) for reversal claim	Required
526-FQ	Additional Message Information	x(200)	A	This field contains response-specific text	Required if additional message is needed

Table 4.15 – Response Claim Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>22</b> – Response claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	x(1)	A	<b>1</b> – Rx billing	Mandatory
402-D2	Prescription/Service Reference Number	9(7)	N	Prescription number	Mandatory

## Reversal Rejected Response

Table 4.16 – Response Header Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
102-A2	Version/Release Number	x(2)	A	<b>51</b> – Version 5.1	Mandatory
103-A3	Transaction Code	x(2)	A	<b>B2</b> – Reversal	Mandatory
109-A9	Transaction Count	x(1)	A	<b>1</b> – One occurrence <b>2</b> – Two occurrences <b>3</b> – Three occurrences <b>4</b> – Four occurrences	Mandatory
501-F1	Header Response Status	x(1)	A	<b>A</b> – Accepted	Mandatory
202-B2	Service Provider ID Qualifier	x(2)	A	<b>05</b> – Medicaid	Mandatory <i>Note: This qualifier does not guarantee IHCP enrollment, unless the provider is currently enrolled.</i>
201-B1	Service Provider ID	x(15)	A	Provider ID is returned from the ID received on the request	Mandatory <i>Note: If the service provider is also enrolled in IHCP, this is the <b>same</b> provider number.</i>
401-D1	Date of Service	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Mandatory

Table 4.17 – Response Message Segment: Optional

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>20</b> – Response message	Mandatory when segment is present
504-F4	Message	x(200)	A	This field contains response-specific text	Required if additional message is needed

Table 4.18 – Response Status Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>21</b> – Response status	Mandatory
112-AN	Transaction Response Status	x(1)	A	R – Rejected	Mandatory
503-F3	Authorization Number	x(20)	A	13-character Internal Control Number (ICN) for reversal claim	Required
510-FA	Reject Count	9(2)	N	Reject count	Required
511-FB	Reject Code	x(3)	A	See <i>NCPDP Data Dictionary, Appendix F - Reject Codes</i>	Required
526-FQ	Additional Message Information	x(200)	A	This field contains response-specific text	Required if additional message is needed

Table 4.19 – Response Claim Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	x(2)	A	<b>22</b> – Response claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	x(1)	A	<b>1</b> – Rx billing	Mandatory
402-D2	Prescription/Service Reference Number	9(7)	N	Prescription number	Mandatory

## Transmission Rejected; Transaction Rejected Response

Table 4.20 – Response Header Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
102-A2	Version/Release Number	X(2)	A	Same value as in request	Mandatory
103-A3	Transaction Code	X(2)	A	Same value as in request	Mandatory
109-A9	Transaction Count	X(1)	A	Same value as in request	Mandatory
501-F1	Header Response Status	X(1)	A	<b>R</b> – Rejected	Mandatory
202-B2	Service Provider ID Qualifier	X(2)	A	Same value as in request	Mandatory
201-B1	Service Provider ID	X(15)	A	Same value as in request	Mandatory
401-D1	Date of Service	9(8)	N	Same value as in request	Mandatory

Table 4.21 – Response Message Segment: Optional

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	<b>20</b> – Response message	Required when segment is present
504-F4	Message	X(200)	A	This field contains response-specific text	Required If additional message is needed

Table 4.22 – Response Status Segment: Mandatory

Field	Field Name	Field Format	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	<b>21</b> – Responses Status	Mandatory
112-AN	Transaction Response Status	X(1)	A	<b>R</b> – Rejected	Mandatory One per transaction
510-FA	Reject Count	9(2)	N	Reject count	Required
511-FB	Reject Code	X(3)	A	See <i>NCPDP Data Dictionary, Appendix F - Reject Codes</i>	Required
526-FQ	Additional Message Information	X(200)	A	This field contains response-specific text	Required if additional message is needed



## Section 5: NCPDP Version 1.1 Batch Transaction

Table 5.1 – Header Record Definition: Mandatory

(Only one Version 1.1 Transaction Header Record per batch transmission file)

Field	Field Name	Field Format	Type	Value	Comments
880-K4	Text Indicator	X(1)	A	Start of Text (STX) – <b>X02</b>	Mandatory
701	Segment Identifier	X(2)	A	<b>00</b> – File header	Mandatory
880-K6	Transmission Type	X(1)	A	<b>T</b> – Transaction <b>R</b> – Response <b>E</b> – Error	Mandatory
880-K1	Sender ID	X(24)	A	The four-byte sender ID assigned by the Indiana Health Coverage Programs (IHCP) (Trading Partner ID)	Mandatory
806-5C	Batch Number	9(7)	N	Assigned by the sender and must match the Transaction Trailer Batch Number field	Mandatory
880-K2	Creation Date	9(8)	N	Date Filled Format – CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Mandatory
880-K3	Creation Time	9(4)	N	Time Filled Format – HHMM HH – Hour MM – Minute	Mandatory
702	File Type	X(1)	A	<b>P</b> – Production <b>T</b> – Test	Mandatory
102-A2	Version/Release Number	X(2)	A	<b>11</b> – Version 1.1	Mandatory
880-K7	Receiver ID	X(24)	A	Indiana Medicaid BIN # – <b>610467</b>	Mandatory
880-K4	Text Indicator	X(1)	A	End of text (ETX) – <b>X03</b>	Mandatory

Table 5.2 – Detail Data Record Definition: Required

Field	Field Name	Field Format	Type	Value	Comments
880-K4	Text Indicator	X(1)	A	Start of text (STX) – <b>X02</b>	Mandatory
701	Segment Identifier	X(2)	A	<b>G1</b> – Detail data record	Mandatory
880-K5	Transaction Reference Number	X(10)	A	The Transaction Reference Number is assigned by the pharmacy and is used to explicitly tie a response back to the original claim	Mandatory
	NCPDP Version 5.1 Data Record			The data record to be transmitted in this batch standard follows the <i>National Council on Prescription Drug Programs (NCPDP) Telecommunication Standard Version 5.1</i> . Length varies	Mandatory Use the IHCP Version 5.1 Payer Sheet for the Detail Data Record instructions
880-K4	Text Indicator	X(1)	A	End of text (ETX) – <b>X03</b>	Mandatory

Table 5.3 – Batch Transaction Trailer Definition: Required

(Only one Version 1.1 Transaction Trailer Record per batch transmission file)

Field	Field Name	Field Format	Type	Value	Comments
880-K4	Text Indicator	X(1)	A	Start of text (STX) – <b>X02</b>	Mandatory
701	Segment Identifier	X(2)	A	<b>99</b> – File trailer	Mandatory
806-5C	Batch Number	9(7)	N	Assigned by the sender and must match the Transaction Header Batch Number field.	Mandatory
751	Record Count	9(10)	N	Count of Version 1.1 Batch records (one Version 1.1 Batch Transaction Header, One or many Version 1.1 Batch Transaction Detail Data Records, and one Version 1.1 Batch Transaction Trailer).  The record count field includes the total number of Version 1.1 records in the batch, including the header and trailer records.  The maximum number of records in a file is 9,999,999,999 including one Transaction Header and one Transaction Trailer.	Mandatory

Field	Field Name	Field Format	Type	Value	Comments
504-F4	Message	X(35)	A	The message field can be used to further explain the reasons why the entire batch is in error or any other information that needs to be sent regarding the batch. This field should only contain informational data and should not contain required data.	Situational
880-K4	Text Indicator	X(1)	A	End of text (ETX) - <b>X03</b>	Mandatory



# Index

<b>B</b>	
Batch transaction.....	5-1
Batch transaction trailer definition.....	5-2
Billing claim request.....	3-1
Billing paid response.....	4-1
Billing reject response.....	4-4
<b>C</b>	
Claim reversal.....	3-11
Claim segment.....	3-3, 3-12
Clinical segment.....	3-10
COBOL.....	1-1
Comments.....	1-1
Compound segment.....	3-8
Coordination of benefits segment.....	3-5
<b>D</b>	
Detail data record definition.....	5-2
DUR/PPS segment.....	3-6
<b>F</b>	
Field.....	1-1
Field format.....	1-1
Field name.....	1-1
Format	
Fixed.....	1-2
Variable.....	1-2
Variable length.....	1-2
<b>G</b>	
General transaction formatting.....	2-1
<b>H</b>	
Header record definition.....	5-1
<b>I</b>	
<i>Implementation Guide</i> .....	1-2
<i>IndianaAIM</i> .....	1-2
Insurance segment.....	3-2
Introduction	
Overview.....	1-1
<b>N</b>	
NCPDP.....	1-1
NCPDP Version 1.1.....	1-1
Batch transaction.....	5-1
NCPDP Version 5.1.....	1-1, 2-1
Field separator.....	2-1
General transaction formatting.....	2-1
Group separator.....	2-1
Implied decimals.....	2-3
Overpunch sign.....	2-2
Request.....	3-1
Responses.....	4-1
Segment separator.....	2-1
Transaction.....	3-1
Transaction rejected response.....	4-11
Transaction set.....	2-1
Transmission rejected.....	4-11
Truncation.....	2-3
Variable usage.....	2-2
NCPDP Version 5.1 response	
Billing paid.....	4-1
Billing reject.....	4-4
Rebill paid.....	4-1
Rebill reject.....	4-4
Reversal approved.....	4-7
Reversal rejected.....	4-9
NCPDP Version 5.1 transaction	
Billing claim request.....	3-1
Claim reversal.....	3-11
Rebill claim request.....	3-1
<b>O</b>	
Other payments segment.....	3-5
<b>P</b>	
Patient segment.....	3-2
Prescriber segment.....	3-5
Pricing segment.....	3-7
<b>R</b>	
Rebill claim request.....	3-1
Rebill paid response.....	4-1
Rebill reject response.....	4-4
Response	
Claim segment.....	4-2, 4-6, 4-9, 4-10
DUR/PPS segment.....	4-3, 4-6
Header segment.....	4-1, 4-4, 4-7, 4-9, 4-11
Message segment.....	4-5, 4-8, 4-10, 4-11
Pricing segment.....	4-2
Status segment.....	4-2, 4-5, 4-8, 4-10, 4-11
Response	
Message segment.....	4-2
Reversal approved response.....	4-7
Reversal rejected response.....	4-9
Revision history.....	iii
<b>T</b>	
Table of contents.....	v

Transaction header segment..... 3-1, 3-11  
Transaction rejected response ..... 4-11  
Transmission rejected ..... 4-11  
Type ..... 1-1

**V**

Value ..... 1-1