MMIS Replacement Project (MRP)

National Council for Prescription Drug Programs (NCPDP) D.0 Claim Billing or Encounter Payer Sheet Standard Companion Guide

Companion to National Council for Prescription Drug Programs (NCPDP) D.0 Claim Billing or Encounter Payer Sheet Implementation Guide

September 2022

Version 1.0

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** Start of Request Claim Billing/Claim Re-Bill (B1/B3) Payer Sheet Template**

1. General Information

Payer Name: Mississippi Division of Medicaid	**Date**: September 28, 2022	
Plan Name/Group Name: Mississippi Division of Medicaid	**BIN**: 025151	**PCN**: *DRMSTEST - TEST* *DRMSPROD – PROD* *ENCOUNTER – For CCOs*
Processor: Gainwell Technologies		
Effective as of: *August 2022*	**NCPDP Telecommunication Standard Version/Release #**: D.0	
NCPDP Data Dictionary Version Date: *April 2022*	**NCPDP External Code List Version Date**: *October 2020 (version October 2021 will become required in 10/22)*	

Contact/Information Source: For questions, please call 1 800-884-3222. Website: EDI Technical Documents | Mississippi Division of Medicaid (ms.gov)

Certification Testing Window: Certification is not required.

Certification Contact Information: N/A

Provider Relations Help Desk Info: 1 800-884-3222

Other versions supported: No other versions supported

2. Other Transactions Supported

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

Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal
B3	Claim Re-Bill

2.1. Field Legend for Columns

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
Required	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
Qualified Requirement	**RW**	“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 Re-Bill transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

Situational or optional data elements that are not mandatory should be eliminated or truncated. Data compression of leading zeros in numeric (“N” & “D”) fields and trailing spaces in the alphanumeric (“A/N”) fields should be suppressed to decrease transmission time.

2.2. Claim Billing/Claim Re-Bill Transaction

The following lists the segments and fields in a Claim Billing or Claim Re-Bill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Transaction Header Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used		

Transaction Header Segment		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
1Ø1-A1	BIN NUMBER	Ø25151	M	*MS XIX accepts value* Ø25151
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	Values: B1 = Billing B2 = Reversal B3 = Rebill	M	B1 - Billing B2 - Reversal B3 - Rebill
1Ø4-A4	PROCESSOR CONTROL NUMBER	DRMSTEST = Test DRMSPROD = Prod ENCOUNTER = CCOs	M	DRMSTEST or DRMSPROD For CCOs, “ENCOUNTER” is expected
1Ø9-A9	TRANSACTION COUNT	Values: Ø1 = One occurrence Ø2 = Two occurrences Ø3 = Three occurrences Ø4 = Four occurrences	M	One transaction for B2 or compound claim; Four allowed for B1 or B3.
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = NPI	M	Code qualifying the ‘Service Provider ID’ (Field # 2Ø1-B1). Ø1 – National Provider Identifier (NPI)
2Ø1-B1	SERVICE PROVIDER ID	1Ø-Digit National Provider Identifier (NPI)	M	
4Ø1-D1	DATE OF SERVICE	CCYYMMDD	M	8-digit date of service format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/ CERTIFICATION ID	ØØØØØØØØØØ	M	Submit with all zeroes.

Insurance Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent	X	

Insurance Segment Segment Identification (111-AM) = "Ø4"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
3Ø2-C2	CARDHOLDER ID	9-Digit Mississippi Medicaid ID Number	M	MS Medicaid identification number (patient specific) potential for a suffix to indicate copay bypass, etc.
312-CC	CARDHOLDER FIRST NAME		R	
313-CD	CARDHOLDER LAST NAME		R	
314-CE	HOME PLAN		RW	
524-FO	PLAN ID	MS_TXIX	R	*For Mississippi this value is MS_TXIX – Mississippi Title 19.*
3Ø1-C1	GROUP ID	SIPPI	R	MS XIX accepts value SIPPI.
3Ø3-C3	PERSON CODE	ØØ1	R	MS XIX accepts value ØØ1.
3Ø6-C6	PATIENT RELATIONSHIP CODE	0 - Not Specified 1 - Cardholder 2 - Spouse 3 - Child 4 - Other	RW	K-Baby Note: Use NCPDP 306-C6 Value '3' to indicate K-Baby claim. Medicaid ID submitted should be that of the Mother, the First/Last Name, DOB and Gender values should be those of the infant/baby.
36Ø-2B	MEDICAID INDICATOR	Two-character State Postal Code indicating the state where Medicaid coverage exists.	RW	Imp Guide: Required, if known, when patient has Medicaid coverage. Example: MS
115-N5	MEDICAID ID NUMBER		RW	

Patient Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent	X	

Patient Segment Segment Identification (111-AM) = "Ø1"		Claim Billing/Claim Re-Bill		
Field	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
3Ø4-C4	DATE OF BIRTH	CCYYMMDD	R	8-digit date of birth format = CCYYMMDD
3Ø5-C5	PATIENT GENDER COD	Values: Ø = Not Specified	R	

Patient Segment Segment Identification (111-AM) = "Ø1"		Claim Billing/Claim Re-Bill		
Field	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		1 = Male 2 = Female		
31Ø-CA	PATIENT FIRST NAME		R	Required when the patient has a first name; must support special characters Required for a patient name validation, up to 12-byte characters.
311-CB	PATIENT LAST NAME		R	Required when the patient has a last name; must support special characters Required for a patient name validation, up to 15-byte characters.
3Ø7-C7	PLACE OF SERVICE		RW	*MS XIX accepts all valid values.* *11 = Office (required for Clinician Administered Drug/Implantable Drug System Devices (CADD) billing as defined by MS DOM)*
335-2C	PREGNANCY INDICATOR	Values: Blank = Not Specified 1 = Not Pregnant 2 = Pregnant	RW	*Payer requirement: Required if the patient is known to be pregnant.*
384-4X	PATIENT RESIDENCE	Values: ØØ = Not Specified Ø1 = Home Ø2 = Skilled Nursing Facility. PART B ONLY Ø3 = Nursing Facility Ø4 = Assisted Living Facility Ø5 = Custodial Care Facility. PART B ONLY Ø6 = Group Home Ø7 = Inpatient Psychiatric Facility Ø8 = Psychiatric Facility – Partial Hospitalization Ø9 = Intermediate Care Facility/Mentally Retarded	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement: Same as Imp Guide*

Patient Segment Segment Identification (111-AM) = "Ø1"		Claim Billing/Claim Re-Bill		
Field	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		1Ø = Residential Substance Abuse Treatment Facility 11 = Hospice 12 = Psychiatric Residential Treatment Facility 13 = Comprehensive Inpatient Rehabilitation Facility 14 = Homeless Shelter 15 = Correctional Institution		

Claim Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent	X	
This payer supports partial fills	X	

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-Bill		
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	12-Bytes	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Values: ØØ = Not specified Ø3 = National Drug Code (NDC)	M	ØØ - Must be submitted for compounds Ø3 - For non-compound claims
4Ø7-D7	PRODUCT/SERVICE ID	Values: NDC for non-compound claims "Ø" for compound claims	M	11-digit NDC "Ø" for compound claims
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER		RW	
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	CCYYMMDD	FFS – N Encounter - M	CCOs must submit the date they originally received the claim from the pharmacy.

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				This usage is outside the norm for NCPDP claims but requested by MS DOM for CCO's encounters. 8-digit date of service format = CCYYMMDD
442-E7	QUANTITY DISPENSED	Metric Decimal Quantity	R	
4Ø3-D3	FILL NUMBER	Values: ØØ = Original dispensing Ø1–99 = Refill number - Number of the replenishment	R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	Values: 1 = Not a Compound 2 = Compound	RW	*MS XIX accepts values 1 or 2* *See Compound Segment for support of multi-ingredient compounds.*
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Values: Ø = No Product Selection Indicated 7 = Substitution not allowed – brand drug mandated by law	RW	*MS XIX accepts values Ø or 7*
414-DE	DATE PRESCRIPTION WRITTEN	CCYYMMDD	R	
415-DF	NUMBER OF REFILLS AUTHORIZED	Values: ØØ = No refills authorized Ø1-99 = Authorized Refill number with 99 being as needed, refills unlimited	R	
419-DJ	PRESCRIPTION ORIGIN CODE	Values: 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile 5 = Pharmacy	RW	For COVID-19 and Flu vaccine administration where the pharmacist is also the prescriber, please send value '5 – Pharmacy'. This must be included with 42Ø-DK Submission Clarification Code '42 – Prescriber ID is valid and prescribing requirements have been validated' to prevent claim from denying with NCPDP reject 42. The Prescriber ID is the pharmacy store NPI number.

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
354-NX	SUBMISSION CLARIFICATION CODE COUNT	1, 2. 3 Maximum count of 3.	RW	*Imp Guide:* Required if Submission Clarification Code (42Ø-DK) is used. On 8/31/2021, it was discovered that this field was not included on our payer sheet and is needed if 42Ø-DK is used. This value must be on claims that send a 42Ø-DK value. *Payer Requirement: Same as Imp Guide*
42Ø-DK	SUBMISSION CLARIFICATION CODE	Values: Ø2 = Other Override Ø6 = Starter Dose	RW	Effective December 11, 2020, for dual dose COVID vaccination administrations, send value 'Ø2 – Override' for the first administration and value 'Ø6 – Starter Dose' for the second administration.
		Ø7 = Medically Necessary – for additional doses of COVID vaccine		Effective August 12, 2021, FDA amended the EUAs for Pfizer & Moderna COVID vaccines to allow the use of an additional dose in certain immunocompromised individuals, send value 'Ø7 – Medically Necessary' for an additional dose.
		1Ø = Program Compliance – for additional doses of COVID vaccine		Effective September 20, 2021, to comply with the latest NCPDP and PREP Act billing guidelines for COVID-19 Vaccines, allow the use of value '1Ø – Program Compliance' – to identify a booster dose for the broader population, those with warning immunity.
		13 = Payer-Recognized Emergency/Disaster Assistance Request		Required during officially declared emergencies when it is necessary to override service limit edits.
		2Ø = 34ØB Drug		Effective November 1, 2018, providers who bill drugs purchased through the 34ØB program must send a value of '20 – 34ØB' in NCPDP field 42Ø-DK Submission Clarification Code in conjunction with a

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				value of '08 – 34ØB b' in NCPDP field 423-DN Basis of Cost Determination. Please also include a value in the 354-NX field.
		42 = Prescriber ID submitted valid and prescribing requirements valid		For COVID-19 and Flu vaccine administration where the pharmacist is also the prescriber, please send value '42 – Prescriber ID is valid and prescribing requirements have been validated'. This must be included with 419-DJ Prescription Origin Code value '5 – Pharmacy', to prevent claim from denying with NCPDP reject 42. The Prescriber ID is the pharmacy store NPI number. Up to 3 occurrences of Submission Clarification Code are permitted.
46Ø-ET	QUANTITY PRESCRIBED		RW	Required when billing for DEA Schedule II drugs.
3Ø8-C8	OTHER COVERAGE CODE	Values: ØØ = Not Specified by patient Ø1 = No Other Coverage Ø2 = Other coverage exists-payment collected Ø3 = Other Coverage Billed - claim not covered Ø4 = Other coverage exists-payment not collected	RW	Required for Coordination of Benefits OCC Ø8 is not allowed
429-DT	SPECIAL PACKAGING INDICATOR	Values: 1 = Not Unit Dose 2 = Manufacturer Unit Dose 3 = Pharmacy Unit Dose 4 = Custom Packaging 5 = Multi-drug compliance packaging	RW	Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility. Payer Requirement:
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	Values: Ø1 = UPC	RW	Required on partial or completion fills

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		Ø2 = HRI Ø3 = NDC Ø4 = UPN Ø6 = DUR/PPS Ø7 = CPT4 Ø8 = CPT5 Ø9 = HCPCS 1Ø = PPAC 11 = NAPPI 12 = EAN 15 = GCN 28 = FDB Med Name ID 29 = FDB Routed Name ID 3Ø = FDB Rtd. Dos. Form Med ID 31 = FDB MedID 32 = GCN_SEQ_NO 33 = HICL_SEQ_NO 38 = RxNorm Semantic Clinical Drug (SCD) 39 = RxNorm Semantic Branded Drug (SBD) 4Ø = RxNorm Generic Package (GPCK) 41 = RxNorm Branded Package (BPCK) 42 = Elsevier/Gold Standard Marketed Product Identifier (MPid) 43 = Elsevier/Gold Standard Product Identifier (ProdID) 44 = Elsevier/Gold Standard Specific Product Identifier (SPID) 45 = Device Identifier (DI) 99 = Other		
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE		RW	Required on partial or completion fills.
446-EB	ORIGINALLY PRESCRIBED QUANTITY		RW	Required on partial or completion fills.
454-EK	SCHEDULED PRESCRIPTION ID NUMBER		RW	*Imp Guide:* Required, if necessary, for state/federal/regulatory agency programs Payer Requirement: Follow State regulatory guidance

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				for products that require a scheduled prescription ID number *This field is primarily intended to be used on a Controlled Substance Reporting (C1) or Controlled Substance Reporting Rebill (C3) transaction. It may also be submitted on a Billing (B1) transaction.*
6ØØ-28	UNIT OF MEASURE	Values: EA = Each GM = Grams ML = Milliliters	R	
418-DI	LEVEL OF SERVICE	Ø3 = Emergency	RW	Required for Emergency Supply; "Ø3" only allowed value. Required when submitting a claim for a 72-hour Emergency Supply.
461-EU	PRIOR AUTHORIZATION TYPE CODE		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement: Same as Imp Guide*
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement: Same as Imp Guide*
343-HD	DISPENSING STATUS		RW	*Imp Guide:* Required for the partial fill or the completion fill of a prescription. *Payer Requirement: Same as Imp Guide.*
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	*Imp Guide:* Required for the partial fill or the completion fill of a prescription. *Payer Requirement: Same as Imp Guide.*
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	*Imp Guide:* Required for the partial fill or the completion fill of a prescription. *Payer Requirement: Same as Imp Guide.*
357-NV	DELAY REASON CODE		RW	*Imp Guide:* Required when needed to specify the

Claim Segment Segment Identification (111-AM) = "Ø7"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				reason that submission of the transaction has been delayed. *Payer Requirement: Same as Imp Guide.*
995-E2	ROUTE OF ADMINISTRATION		RW	*Imp Guide:* Required if specified in trading partner agreement. *Payer* Requirement *Required when submitting compounds claims.*
996-G1	COMPOUND TYPE	Values: Ø1 = Anti-infective Ø2 = Ionotropic Ø3 = Chemotherapy Ø4 = Pain management Ø5 = TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition Ø6 = Hydration Ø7 = Ophthalmic 99 = Other	RW	*Imp Guide:* Required if specified in trading partner agreement. *Payer Requirement: Same as Imp Guide.*
147-U7	PHARMACY SERVICE TYPE	Values: Ø1 = Community/Retail Pharmacy Services Ø2 = Compounding Pharmacy Services Ø3 = Home Infusion Therapy Provider Services Ø5 = Long-Term Care Pharmacy Services Ø8 = Specialty Care Pharmacy Services	RW	*Imp Guide:* Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer. *Payer Requirement: Same as Imp Guide.*

Pricing Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent	X	

Pricing Segment Segment Identification (111-AM) = "11"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		RW	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement: Same as Imp Guide.*
433-DX	PATIENT PAID AMOUNT SUBMITTED		RW	
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	*Imp Guide:* Required when submitting claims for vaccine administration. Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement*: Same as Imp Guide.
48Ø -H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		RW	
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		RW	
426-DQ	USUAL AND CUSTOMARY CHARGE		R	34ØB pharmacies must submit actual acquisition cost in this field. Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION	Values: Ø8 = 34ØB/ Disproportionate Share Pricing/Public Health Service 15 = Free Product of No Associated Cost	RW	Imp Guide: Required if needed for receiver claim/encounter adjudication. Payer Requirement: Claims for products purchased through the 34ØB Program must be submitted with the following value: Ø8 Effective November 1, 2018, providers who bill drugs purchased through the 34ØB program must send a value of '2Ø – 34ØB'' in NCPDP field 42Ø-DK Submission Clarification Code in conjunction with a value of 'Ø8 – 34ØB' in NCPDP field 423-

Pricing Segment Segment Identification (111-AM) = “11”		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				DN Basis of Cost Determination. Effective December 11, 2020, providers who bill for COVID-19 vaccinations where the ingredient cost is $0, please submit value of ’15 – “Free Product or No Associated Cost”’.

Pharmacy Provider Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required only if law or regulation required.

Prescriber Segment Segment Identification (111-AM) = "Ø2"		Pharmacy Provider		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
465-EY	PROVIDER ID QUALIFIER	Values: Ø1 = Drug Enforcement Administration (DEA) Ø2 = State License Ø3 = Social Security Number (SSN) Ø4 = Name Ø5 = National Provider Identifier (NPI) Ø6 = Health Industry Number Ø7 = State Issued 99 = Other	RW	Claim Billing Encounter: Required if Provider ID (444-E9) is used
444-E9	PROVIDER ID		RW	Claim Billing Encounter: Required if necessary for state/federal/regulatory agency programs. Required if necessary to identity the individual responsible for dispensing of the prescription. Required if needed for reconciliation of encounter-reported data or encounter reporting.

Prescriber Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent	X	

Prescriber Segment Segment Identification (111-AM) = "Ø3"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = NPI	R	MS XIX requires the National Provider Identifier (NPI) (Ø1).
411-DB	PRESCRIBER ID	Prescriber Individual NPI	R	Required; Must submit valid NPI.

Prescriber Segment Segment Identification (111-AM) = "Ø3"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
427-DR	PRESCRIBER LAST NAME		RW	Imp Guide: Required when the Prescriber ID (411-DB) is not known. Required if needed for Prescriber ID (411-DB) validation/clarification.
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	12 = DEA	RW	
421-DL	PRIMARY CARE PROVIDER ID		RW	Prescriber's DEA number.
47Ø-4E	PRIMARY CARE PROVIDER LAST NAME		RW	
364-2J	PRESCRIBER FIRST NAME		RW	
365-2K	PRESCRIBER STREET ADDRESS		RW	
366-2M	PRESCRIBER CITY ADDRESS		RW	
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS		RW	
368-2P	PRESCRIBER ZIP/POSTAL ZONE		RW	

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent		
This Segment is Required	X	Maximum of 5 times. For CCOs, segment is required whether TPL exists on the original pharmacy claim or not. If there is no TPL, on the original claim, then a count of 1 is expected in field 337-4C. The CCO's payment and/or reject information is expected in Segment AMØ5. If there is TPL on the claim, then a count of TPL payers +1 (for CCO's segment) is expected in field 337-4C.

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is situational	X	Maximum of 9 times FFS and ALL Others, segment is required only for secondary, tertiary, etc., claims. It is used when a receiver needs payment information from other receivers to perform claim/encounter determination. This may be in the case of primary, secondary, tertiary etc., health plan coverage for example. The Coordination of Benefits/Other Payments Segment is mandatory for a Claim Billing or Encounter request to a downstream payer. It is used to assist a downstream payer to uniquely identify a claim or encounter in case of duplicate processing. The segment is mandatory if required under provider payer contract or mandatory on claims where this information is necessary for adjudication of the claim.
Scenario 1 – Other Payer Amount Paid Repetitions Only	X	OCC codes Ø, 1, 2, 3, and 4 Supported (no co-pay only billing allowed).

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-Bill Scenario 1 – Other Payer Amount Paid Repetitions Only		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	CCOs 1, 2, 3, 4, 5 FFS 1, 2, 3, 4, 5, 6, 7, 8, 9	FFS – N Encounter – R	For CCOs, field is required CCO maximum count of 5 FFS and All Others field is required if submitting other coverage/payment information. Maximum count of 9. ***NOTE:*** *The CCO reporting would be in the first/primary COB count (337-4C).*
338-5C	Other Payer Coverage Type		FFS – N Encounter – R	For CCOs, "Ø1" is expected if CCO is the primary payer. FFS and All Others Required if patient has other coverage.
339-6C	OTHER PAYER ID QUALIFIER	Values: Ø3 = BIN 99 = Other	FFS – RW Encounter – R	For CCOs, "99" is expected to denote CCO is submitting CCO's Medicaid Number in field 34Ø-7C. For true TPL, this is a pass through from the original NCPDP pharmacy claim. FFS and All Others Required if Other Payer ID (Field # 34Ø-7C) is used.
34Ø-7C	OTHER PAYER ID		FFS – RW Encounter – R	For CCO's COB payer segment, CCO's Medicaid ID

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-Bill Scenario 1 – Other Payer Amount Paid Repetitions Only		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				expected for CCO's plan as assigned by DOM/Gainwell. For true TPL, value is pass through from the original NCPDP pharmacy claim. FFS and All Others Required if COB segment is used.
443-E8	OTHER PAYER DATE		FFS – RW Encounter – R	For CCO's COB segment, expected value is date CCO paid claim. For true TPL, value is pass through from the original NCPDP pharmacy claim. FFS and All Others Imp Guide: Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
993-A7	INTERAL CONTROL MUMBER		FFS – RW Encounter – R	For CCO's COB segment, expected value is CCO's internal claim number. For true TPL, value is pass through from the original NCPDP pharmacy claim and may not be mandatory/required.
341-HB	OTHER PAYER AMOUNT PAID COUNT	CCOs 1, 2, 3, 4, 5 FFS 1, 2, 3, 4, 5, 6, 7, 8, 9	FFS – RW Encounter – R	For CCO's COB segment, up to a maximum of 5 is expected Count of Other Payer Amounts Submitted. For true TPL, value is pass through from the original NCPDP pharmacy claim. FFS and All Others Imp Guide: Required if Other Payer Amount Paid Qualifier (342-HC) is used. Payer Requirement: Same as Imp Guide. Maximum count of 9. **NOTE:** *Within the primary CCO loop there would be five other payer amount paid loops (341-HB) to report the calculated, allowed, dispensing fee, admin fee, and ingredient cost (using the noted qualifiers).*
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Values: Ø1 = Delivery	RW	All value qualifiers are accepted as payment from the other payer.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-Bill Scenario 1 – Other Payer Amount Paid Repetitions Only		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		Ø2 = Shipping Ø3 = Postage Ø4 = Administrative Ø5 = Incentive Ø6 = Cognitive Service Ø7 = Drug Benefit Ø9 = Compound Preparation Cost 1Ø = Sales Tax ~~11 = Medication Administration~~ 12 = Regulatory Fee		For CCOs, will send one segment for COB Segment from the following: 342-HC Other Payer Amount Paid Qualifier – Ø1 – Delivery 431-DV Other Payer Amount Paid – **CCO Calculated Allowed Amount** 342-HC Other Payer Amount Paid Qualifier – Ø2 – Shipping 431-DV Other Payer Amount Paid – **CCO Paid Amount** 342-HC Other Payer Amount Paid Qualifier – Ø4 – Administrative 431-DV Other Payer Amount Paid – **CCO Dispensing Fee Paid** 342-HC Other Payer Amount Paid Qualifier – Ø7 – Drug Benefit 431-DV Other Payer Amount Paid – **CCO Ingredient Cost Paid** 342-HC Other Payer Amount Paid Qualifier – Ø5 – Incentive 431-DV Other Payer Amount Paid – **CCO Vaccine Administration Fee Paid** TPL applied by the CCO would be reported via an additional/tertiary COB loop. Allow for the use of 342-HC Other Payer Amount Paid Qualifier of Ø6-Cognitive Services For true TPL, value is pass through from the original NCPDP pharmacy claim. FFS and All Others Required on all COB claims with Other Coverage Code of 2.
431-DV	OTHER PAYER AMOUNT PAID		FFS – RW Encounter – R	*For CCOs, send up to 5 maximum, as described above for field 342-HC.* *For true TPL, value is pass through from the original NCPDP pharmacy claim.* *FFS and All Others Imp Guide: Required if other payer has approved payment for some/all the billing.*

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-Bill Scenario 1 – Other Payer Amount Paid Repetitions Only		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				NOTE: *The CCO reporting would be in the first/primary COB count (337-4C).* *Within the primary CCO loop there would be five other payer amount paid loops (341-HB) to report the calculated, allowed, dispensing fee, admin fee, and ingredient cost (using the noted qualifiers).* *Within the primary CCO loop the patient copay amount would be reported in one 353-NR loop (other payer patient responsibility amount count) using 351-NP qualifier 05 and 352-NQ.* *TPL would be reported in a secondary COB loop where we would sum the other payer amount paid amounts and use that as the TPL amount.*
471-5E	OTHER PAYER REJECT COUNT	1, 2, 3, 4, 5	FFS – RW Encounter – R	For CCOs, field is required when CCOs are communicating CCO's rejected claims per DOM's request. For true TPL, value is pass through from the original NCPDP pharmacy claim. FFS and All Others *Imp Guide:* Required if other payer has approved payment for some/all the billing.
472-6E	OTHER PAYER REJECT CODE		FFS – RW Encounter – R	Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered). ***NOTE:*** *This field must only contain the NCPDP Reject Code (511-FB) values.*
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Ø1 Through 25	RW	Required if Other Payer Patient Responsibility Amount Qualifier (351-NP) is used. Maximum of 25 occurrences. ***NOTE:*** *Within the primary CCO loop the patient copay amount would be reported in one 353-NR loop (other payer patient responsibility amount*

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-Bill Scenario 1 – Other Payer Amount Paid Repetitions Only		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				count) using 351-NP qualifier 05 and 352-NQ.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø1 = Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Ø2 = Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 = Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 = Amount Exceeding Periodic Benefit Maximum (520-FK) as reported by previous payer. Ø5 = Amount of Copay (518-FI) as reported by previous payer. Ø6 = Patient Pay Amount (505-F5) as reported by previous payer. Ø7 = Amount of Coinsurance (572-4U) as reported by previous payer. Ø8 = Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 = Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø = Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. 11 = Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as	RW	Required when the Payer Patient Responsibility Amount (352-NQ) is used. 351-NP Other Payer Patient Responsibility Amount Qualifier – Ø5 Copay 352-NQ Other Payer Patient Responsibility Amount – **CCO Copay Amount**

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-Bill Scenario 1 – Other Payer Amount Paid Repetitions Only		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		reported by previous payer. 12 = Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer. 13 = Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.		
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	
392-MU	BENEFIT STAGE COUNT	1,2,3,4	RW	Required if Benefit Stage Amount Qualifier (393-MV) is used.
393-MV	BENEFIT STAGE QUALIFIER	Ø1 = Deductible. Ø2 = Initial Benefit. Ø3 = Coverage Gap (donut hole). Ø4 = Catastrophic Coverage 5Ø = Not paid under Part D, paid under Part C benefit (for MA-PD plan) 6Ø = Not paid under Part D, paid as or under a supplemental benefit only 61 = Part D drug not paid by Part D plan benefit, paid as or under a co-administered insured benefit only 62 = Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only. 63 = Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid under Medicaid benefit only of the Medicare/Medicaid (MMP) plan.	RW	Required when the Benefit Stage Amount (394-MW) is used.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"		Claim Billing/Claim Re-Bill Scenario 1 – Other Payer Amount Paid Repetitions Only		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		7Ø = Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing. 8Ø = Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan sponsored negotiated pricing. 9Ø = Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend but is covered by the Part D plan.		
394-MW	BENEFIT STAGE AMOUNT		RW	

DUR/PPS Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required when DUR is returned on Rejection and pharmacy wishes to submit reason DUR rejection should be overridden. Submitted if required to affect outcome of claim related to DUR intervention.

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
473-7E	DUR/PPS CODE COUNTER	1, 2, 3, 4, 5, 6, 7, 8, 9	RW***	*Imp Guide:* Required if DUR/PPS Segment is used. *Payer Requirement:* Same as *Imp Guide.* Maximum of 9 occurrences.
439-E4	REASON FOR SERVICE CODE	Allowed values: DC = Drug Disease (inferred) DD = Drug-Drug Interaction ER = Early Refill	RW***	Required when needed to communicate DUR information.

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		HD = High Dose ID = – Ingredient Duplication LD =Low Dose LR = Underuse MC = Drug-Disease (Reported) MN = Insufficient Duration MX = Excessive Duration PA = Drug-Age PG = Drug-Pregnancy TD=Therapeutic Duplication		
44Ø-E5	PROFESSIONAL SERVICE CODE	Allowed Values: ØØ = No Intervention AS = Patient Assessment CC = Coordination of Care DE = Dosing Evaluation/Determination FE = Formulary Enforcement GP = Generic Product Selection MØ = Prescriber Consulted MA = Medication Administration MR = Medication Review PØ = Patient Consulted PE = Patient Education/Instruction PF = Patient Referral PH = Patient Medication History PM = Patient Monitoring RØ = Pharmacist Consulted Other Source RT = Recommended Laboratory Test SC = Self-Care Consultation	RW***	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered. Effective December 11, 2020, for vaccine administrations, include value "MA – Medication Administered". Required field if there is a DUR alert: MØ = Prescriber Consulted PØ = Patient Consulted RØ = Pharmacist Consulted Other Note: These values are additional to the Valid Values per Translator.

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
		SW = Literature Search/Review TC = Payer/Processor Consulted TH = Therapeutic Product Interchange		
441-E6	RESULT OF SERVICE CODE	Allowed Values: ØØ = Not Specified 1A = Filled As Is, False Positive 1B = Filled Prescription As Is 1C = Filled, with Different Dose 1D = Filled, with Different Directions IE = Filled, with Different Drug 1F = Filled, with Different Quantity 1G = Filled, With Prescriber Approval 1H = Brand-to-Generic Change 1J = Rx to OTC Change 1K = Filled, with Different Dosage Form 2A = Prescription not Filled 2B = Not Filled, Directions Clarified 3A = Recommendation Accepted 3B = Recommendation not Accepted 3C = Discontinued Drug 3D = Regimen Changed 3E = Therapy Changed 3F = Therapy Changed – Cost Increase Acknowledged 3G = Drug Therapy Unchanged 3H = Follow-up Report 3J = Patient Referral 3M = Compliance Aide Provided	RW***	Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service. Required field if there is a DUR alert: 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

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
474-8E	DUR/PPS LEVEL OF EFFORT	Values: ØØ = Not Specified 11 = Level 1 (Lowest) 12 = Level 2 13 = Level 3 14 = Level 4 15 = Level 5 (Highest)	RW	

Compound Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Submitted if the claim dispensed is a compound.

Compound Segment Segment Identification (111-AM) = "1Ø"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	Values: Blank = Not Specified Ø1 = Capsule Ø2 = Ointment Ø3 = Cream Ø4 = Suppository 3Ø5 = Powder Ø6 = Emulsion Ø7 = Liquid 1Ø = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	Values: 1 = Each 2 = Grams 3 = Milliliters	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Ø1 Through 25	M	Maximum 25 ingredients.
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3 = National Drug Code (NDC) – Formatted 11 digits (N)	M	

Compound Segment Segment Identification (111-AM) = "1Ø"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		R	Imp Guide: Required if needed for receiver claim determination when multiple products are billed.
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Values: ØØ = Default Ø1 = AWP Ø2 = Local Wholesaler Ø3 = Direct Ø4 = EAC (Estimated Acquisition Cost) Ø5 = Acquisition Ø6 = MAC (Maximum Allowable Cost) Ø7 = Usual & Customary Ø8 = 34ØB/ Disproportionate Share Pricing Ø9 = Other 1Ø = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost) 13 = Special Patient Pricing	R	Imp Guide: Required if needed for receiver claim determination when multiple products are billed. Required when submitting compounds claims.

Clinical Segment Questions	Check	Claim Billing/Claim Re-Bill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	Required when Diagnosis code is necessary for Claim adjudication. Submitted if the clinical detail will affect the outcome of claims processing.

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
491-VE	DIAGNOSIS CODE COUNT	1,2,3,4,5	RW	Maximum count of 5.

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				Imp Guide: Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. *Payer Requirement: Same as Imp Guide.*
492-WE	DIAGNOSIS CODE QUALIFIER	Value: Ø2 = ICD1Ø	RW***	Required if Diagnosis Code (424-DO) is used. MS XIX Valid Value: Ø2 = International Classification of Diseases (ICD1Ø).
424-DO	DIAGNOSIS CODE		RW***	The value for this field is obtained from the prescriber or authorized representative. Imp Guide: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required, if necessary, for state/federal/regulatory agency programs. Payer Requirement: Required to identify pregnancy.
493-XE	CLINICAL INFORMATION COUNTER	1,2,3,4,5	RW***	Maximum 5 occurrences supported. Required if 494-ZE, 495-H1, 496-H2 are sent. Grouped with Measurement fields (Measurement Date (494-ZE), Measurement Time (495-H1), Measurement Dimension (496-H2), Measurement Unit (497-H3), Measurement Value (499-H4)
494-ZE	MEASUREMENT DATE		RW***	Required, if necessary, when this field could result in different coverage and/or drug utilization review outcome.
495-H1	MEASUREMENT TIME		RW***	Required if time is known or has impact on measurement. Required, if necessary, when this field could result in

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing/Claim Re-Bill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
				different coverage and/or drug utilization review outcome.
496-H2	MEASUREMENT DIMENSION		RW***	Required if Measurement Unit (497-H3) and Measurement Value (499-H4) are used. Required, if necessary, when this field could result in different coverage and/or drug utilization review outcome.
497-H3	MEASUREMENT UNIT		RW***	Required if Measurement Dimension (496-H2) and Measurement Value (499-H4) are used. Required, if necessary, when this field could result in different coverage and/or drug utilization review outcome.
499-H4	MEASUREMENT VALUE		RW***	Required if Measurement Dimension (496-H2) and Measurement Unit (497-H3) are used. Required, if necessary, when this field could result in different coverage and/or drug utilization review outcome.

** End of Request Claim Billing/Claim Re-Bill (B1/B3) Payer Sheet Template**

Appendix A. Change History

Version #	Date of release	Author	Description of change
0.1	12/16/2021	EDI Technical Team	Initial document creation. Field 3Ø6-C6, Page 6 – K-Baby Notes Field 42Ø-DK, Page 10 – COVID-19 Notes Field 34ØB – Varies throughout document
0.2	1/12/2022	Updated Payer Sheets for CSR DO21021902	Field 419-DJ, Page 9 – Payer Situation Notes Additions Field 42Ø-DK, Pages 10 – 11 – Values Additions and Payer Situation Note Additions
0.3	6/23/2022	EDI Technical Team	Field 339-6C, Pages 18 – 19 – Other Payer ID Qualifier CCO instructions for “1D – Medicaid Number” changed to “99 - Other” and qualifier 12 definition added Field 342-HC, Pages 20 – 21 – Other Payer Amount Paid Qualifier CCO instruction updated and removed allowed/calculated amount Field 431-DV, Page 21 - Note added for CCO COB and TPL COB reporting help Field 351-NP, Page 22 - Other Payer Patient Responsibility Amount Qualifier CCO instruction added for Copay Amount Mississippi Logo clean-up Copyright change from 2021 to 2022
0.4	7/26/2022	EDI Technical Team	PROCESSOR CONTROL NUMBER (PCN) Values correction, Pages 4 – 5 341-HB, Page 11, clarification on CCO count “For CCO’s COB segment, up to 5 is expected Count of Other Payer Amounts Submitted.”
0.5	8/05/2022	EDI Technical Team	Corrected PCN values for typo, page 4 from DRMTEST and DRMPROD to DRMSTEST and DRMSPROD.
0.6	8/10/2022	EDI Technical Team	Coordination of Benefits/Other Payments Segment CCO vs FFS clarification on maximum number of loops required, CCO maximum 5, FFS and All Others maximum 9. Pages 18, 19 and 21

Version #	Date of release	Author	Description of change
0.7	8/17/2022	EDI Technical Team	BIN, Page 4 and 5 updated to 025151 Corrected 4Ø3-D3 and 415-DF, Page 9, values to reflect two character position count need
0.8	9/07/2022	EDI Technical Team	342-HC, Page 11, Qualifier 11 – Medication Admiration removed and replace with qualifier Ø5 – Incentive Fields 465-EY and 444-E9, Page 17, additions.
0.9	9/12/2022	EDI Technical Team	PCN (PROCESSOR CONTROL NUMBER) Value “ENCOUNTER” added for CCOs, Pages 4 and 5 339-6C, Page , removed Ø3 = BIN value
1.0	9/28/2022	EDI Technical Team	Situational and Optional Data Elements instructions added Page 4 339-6C, Page , Ø3 = BIN value added back. 524-FO, Page 6, Optional removed R=Required added. 465-EY, Page 17, Values added from ECL (page 181) for ease of reference.