Type 110 - All Claims File

The all claims file, or explanation of benefits (EOB), is an outgoing file produced on a specific cycle. This file contains records of all claims processed or adjusted during the specified cycle. Each cycle is given a unique number referred to in the payment batch number field.

Revision Date	February 1st 2014	Added PBM Program Number
Revision History	September 3rd 2013	Modified GRACE PERIOD column by moving it from HIX13 to CLM33 segment.
	July 9th 2013	Added Health Insurance Marketplace Segment
	June 10th 2013	Revision for Version 24
	March 7th 2013	Added secondary LICS amount
	October 1st, 2012	Updated values for Generic Product Flag
	July 9th, 2012	Revision for Version 20
	June 19th, 2012	Final revisions for Version 19
	January 6th, 2011	Revision for Version 17
	September 27th, 2011	Revision for Version 16
	August 25th, 2011	COB segment updated for looping of sub COB segments
	July 22nd, 2011	Revised for 60-day communication
	June 22nd, 2011	Revised for 90-day communication
	March 21st, 2011	First draft

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Type 110 File Layout Overview

File Header - Header segments are represented on a single row		
Segment ID	**Field Name**	**Required**
ST	Transaction Set Header	M
BGN	Beginning Segment	M
N1	Transmitting Party Identification	M
File Detail - Standard Segments - Each row represents a single claim transaction		
Segment ID	**Field Name**	**Required**
Section Loop Repetitions > 1		
NM1	Member Information	M
PCP	Member Provider Information	O
BEN	Group, Carrier and Benefit Information	M
CLM	Claim Transaction Information	M
CLR	Claim Reject Information	O
CLA	Claim Association Information	O
N51	NCPDP 5.1 Transaction Information	X
ND0	NCPDP D.0 Transaction Information	X
PRV	Provider Information	O
CST	Transaction Cost Information (segment can loop)	M
MST	Member Cost Information	M
DRG	Drug Product Information (segment can loop)	M
DCT	Drug Cost Information - Sub Segment of DRG (segment can loop)	M
COB	Coordination of Benefits Information (segment can loop)	O
CBD	Coordinate of Benefits - Other Payer Amount Paid - Sub Segment of COB (segment can loop)	O
CBP	Coordination of Benefits – Patient Responsibility - Sub Segment of COB (segment can loop)	O
CBS	Coordination of Benefits –Benefit Staging - Sub Segment of COB (segment can loop)	O
CBR	Coordination of Benefits - Reject - Sub Segment of COB (segment can loop)	O
PAN	Prior Authorization Information	O
PRD	Part-D Specific Information	O
BSA	Benefit Staging Amounts - Sub Segment of PRD	O
Supporting Segments - Optional segments provided based on the service agreement		

Segment ID	Field Name	Required
FDB	Drug Product Information - FDB Specific (segment can loop)	O
DRP	Drug Program Information (segment can loop)	O
MSP	Drug Product Information - Medi-Span Specific (segment can loop)	O
MSS	Medicaid Subrogation Services Information	O
PDE	Calculated Prescription Drug Event Information	O
DST	Denied Transaction Cost Information (segment can loop)	O
MSC	Member Miscellaneous Code Information	O
INV	Invoice Information	O
HIX	Health Insurance Marketplace Information	O
File Trailer		
Segment ID	**Field Name**	**Required**
SE	Transaction Set Trailer	M

Notes

M = Mandatory, O = Optional, X= Relational

The PCP segment is only provided if the member has a primary provider on file.

The CLR segment is only provided if the reported transaction is rejected.

The CLA segment is only provided if the reported transaction is associated with another processed transaction.

The N51 segment is only provided if the transaction type in Segment CLM is for NCPDP 5.1.

The ND0 segment is only provided if the transaction type in Segment CLM is for NCPDP D.0.

The PRV segment is only provided if the provider information has been submitted with the transaction.

The PAN segment is only provided if the transaction contains a Prior Authorization.

The COB segment and associated sub segments are only provided if the transaction is a Coordination of Benefits transaction.

The PRD segment is only provided if the transaction is a Part-D transaction.

The FDB Segment is included if the receiver has an active FDB subscription

Segment Details

ST - Transaction Set Header

To indicate the start of a transaction set and to assign a control number

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Transaction Set Identifier Code	M	M	ID	3/3	**Constant:** 110 = All Claims Extract
02	Transaction Set Control Number	M	M	ID	1/20	Equals the job ID assigned by the file extraction program

Notes

BGN - Beginning Segment

To indicate the beginning of a transaction set

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Transaction Set Purpose Code	M	M	ID	2/2	**Constant:** ZZ = Mutually Defined
02	Reference Identification	M	M	AN	1/80	**Constant:** ALL CLAIMS EXTRACT
03	Date	M	M	DT	8/8	Date when the file generation commenced
04	Time	M	M	TM	6/6	Time when the file generation commenced
05	Time Code	M	M	TM	2/2	**Constant:** PT = Pacific Time

Notes

N1 - Transmitting Party Identification

To identify the party transmitting the file by type of organization, name, and code

Ref	Element Name	Req	Src	Type	Min/Max	Comment
01	Entity Identification Code	M	M	ID	2/3	**Accepted Value(s):** **Constant:** 93 = Organization submitting the transaction file
02	Organization Name	M	M	AN	1/60	**Constant:** MEDIMPACT HEALTHCARE SYSTEMS
03	Address 1	M	M	AN	1/55	**Constant:** 10680 TREENA ST.
04	Address 2	M	M	AN	1/55	**Constant:** 5TH FLOOR
05	City	M	M	AN	1/30	**Constant:** SAN DIEGO
06	State or Province Code	M	M	AN	2/2	**Constant:** CA
07	Zip or Postal Code	M	M	AN	1/20	**Constant:** 92131

Notes

NM1 - Member Information

Details on the member associated with the claims transaction

Ref	Element Name	Req	Src	Type	Min/Max	Comment
01	Client HQ Code	M	M	ID	3/10	Client Headquarters Code. Value is designated by MedImpact.
02	Client HQ Description	M	M	AN	1/100	Client description.
03	Member Number	M	P	ID	1/30	ID Number for member on card.
04	Person Code	M	P	ID	2/2	Family position of patient: 00 or 01 = insured 02 = spouse 03 or greater = dependents - 1 = Unmatched or unknown member
05	Relationship Code	M	M	ID	1/1	Relationship to insured. Nonstandard codes are reported as “D”: I = Insured S = Spouse D = Dependent F = Full Time Student H = Handicapped Dependent A = Adult Dependent O = Other (Covered) Dependent In the case where the member is not located, no information is displayed and the min/max length of the field is 0.
06	Last Name	M	P	AN	0/50	Member last name. In the case where the member is not located, no information is displayed and the min/max length of the field is 0.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
07	First Name	M	P	AN	0/50	Member first name. In the case where the member is not located, no information is displayed and the min/max length of the field is 0.
08	Middle Initial	O	P	AN	0/1	Member middle initial.
09	Date of Birth	M	P	DT	0/8	Member date of birth. **Note:** In the case where the member is not located, no information is displayed and the min/max length of the field is 0.
10	Age	O	M	N0	0/3	Age of the member at the point of the transaction's fill date.
11	Gender	O	P	ID	0/1	M = Male F = Female T = Transgender Blank or U = Unknown
12	Alternate Member Number	O	P/M	ID	0/30	Alternative Member Number. Alternative identification number that is referenced to the member.
13	Social Security Number	O	P	N0	0/9	Social Security Identification Number
14	COB Code	O	P	ID	0/1	Will contain the value: 0 = Not Specified 1 = Primary Coverage – Normal processing 2 = Secondary Coverage – Reject 3 = Double Coverage – No copay 4 = Double Coverage – No copay (COBII) 5 = Double Coverage – Pay only Primary 6 = Secondary Coverage – Soft message 9 = Reserved for special purpose
15	COB Prime Code	O	P	ID	0/5	Member's primary insurance code (can be used with COB Code =2).
16	Facility Code	O	P	AN	0/10	Member's facility code.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
17	Medicare Code	O	P	ID	0/1	Medicare coverage for the member (subscriber or spouse only). If the member has Medicare as the primary coverage, will contain the value: B = Medicare Part-B M = Part-A and Part-B D = Medicare Part-D R = Renal dialysis Y = Yes, specifics undefined
18	Medicaid Number	O	P	AN	0/18	Medicaid Identification Number.

Notes

- Data Elements noted as mandatory may be blank for Denied Claims.

PCP - Member Provider Information

Member provider details

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	PCP ID Number	M	P	AN	0/20	Primary Care Provider ID Number.
02	PCP Start Date	M	P	DT	0/8	Primary Care Provider Start Date.
03	PCP End Date	O	P	DT	0/8	Primary Care Provider End Date.

Notes

- This segment is only included if the member associated with the transaction has Primary Care Provider referenced in the system.
- If populated both the PCP ID Number and corresponding start date field has to be populated.

BEN - Benefit Information

Details of the group and the carrier and benefit that the claim transaction relates to

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Group Number	M	P/M	AN	1/10	Group to which the member is associated.
02	Division	O	P/M	AN	0/10	Division to which the member is associated. Allows for a (optional) subset of employees within a company.
03	Start Date	M	P	DT	8/8	Member Effective Date within Group/Division.
04	End Date	O	P	DT	0/8	Last active date for Group/Division.
05	Carrier Number	M	M	ID	1/15	Pharmacy Carrier Identification that the transaction processed under.
06	Carrier Type	M	M	ID	1/1	Indicates the carrier type as designated by the client carrier/network configuration: R= Retail D = Direct Member Reimbursement (DMR) C = Choice 90 M = Mail Order S = Specialty
07	Benefit Code	M	M	ID	1/10	Benefit Code that the transaction processed under.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
08	Tier	O	P/M	N0	0/2	Tier value that the transaction processed under.
09	Beginning Tier	O	P/M	N0	0/2	Notes the drug starting tier number. Only applicable for Tier based formularies.
10	Region Code 1	O	P/M	ID	0/10	Group Region Code 1.
11	Region Code 2	O	P/M	ID	0/10	Group Region Code 2.
12	Region Code 3	O	P/M	ID	0/10	Group Region Code 3.
13	Benefit Sub Type	O	P/M	ID	0/10	Benefit Sub Type Code: Blank = Not specified PB = Medicare Part B PC = Medicare Part C CW = Commercial Wrap MW = Medicaid Wrap Benefit sub-type can be blank for Part D benefit or Commercial benefit.
14	Benefit Type	O	P/M	ID	0/1	Benefit Type

Notes

- The Division Number is dependent on the Group Number being populated.
- Data Elements noted as mandatory may be blank for Denied Claims.

CLM - Claim Transaction Information

Provides information on the submitted claims transaction

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Transaction ID	M	M	ID	1/20	Transaction Identification generated when the transaction is received (also known as Claim ID).
02	Transaction Version	O	T/M	ID	0/2	Indicates the format of the transaction: 51 = NCPDP 5.1 D0 = NCPDP D.0
03	Prescription Number	M	T/M	N0	1/12	Prescription Number
04	Source Code	M	M	M	1/1	Will contain the value: P = Electronic (POS) D = Manual data entry H or F = Batch or data load L = File load
05	Claim Created	M	M	DT	8/8	Date on when the claim transaction was first created in the system (as received by MedImpact).
06	Date of Service	M	T/M	DT	8/8	Date of service of the claim transaction (also known as fill date).
07	Claim Status Code	M	M	ID	1/1	Will contain the value: 0 = NEW 1 = Approved 2 = Denied 3 = Reversed original claim 4 = Reversal entry against original claim

Ref	Element Name	Req	Src	Type	Min / Max	Comment
08	Claim Status Code - Actual	M	M	ID	1/30	Actual Adjudication Status Code. Will contain the value: APPROVED = A transaction that has passed the adjudication process. RLA (REVERSAL) = Offsetting transaction for an unpaid transaction that has been reversed by the pharmacy within the same EOB cycle. RDA (REVERSED) = An approved unpaid transaction which has been reversed by the pharmacy within the same EOB cycle. RLP (REVERSAL) = Offsetting transaction for a paid transaction that has been reversed by the pharmacy after the EOB cycle of the originating transaction was closed. RDP (REVERSED) = An approved transaction which has been reversed by the pharmacy after the EOB cycle of the originating transaction was closed. REJECTED = A transaction that was rejected at the point of sale. The following field (Reject Reason Description) contains details of the rejection reason and code. DUP CLM (DENIED) = A transaction that is denied as the transaction has already been billed.
09	Adjustment Type	O	M	AN	0/30	Adjustment Claim Type.
10	Adjusted Source Claim Identification	O	M	ID	0/20	If the claim transaction is an adjustment, the existing or source claim transaction ID is referenced.
11	Reference Number	O	M	ID	0/20	If claim reversal transaction, will contain the corresponding claim transaction ID that is being reversed.
12	Payment Type Code	M	M	ID	1/2	Will contain the value: 0 = COB Recovery - credit to plan 1 = Pay to pharmacy as calculated 2 = Pay to pharmacy as billed 3 = Pay to member as billed 4 = Pay to member as calculated 5 = Pay to Other Entity as calculated (for example, Subrogation) 6 = Pay to Other Entity as billed (for example, Subrogation)
13	Date Rx Written	O	T/M	DT	0/8	Date that the prescription was written - as submitted by the pharmacy.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
14	Prescription origin code	O	T/M	ID	0/1	Will contain the value: 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile 5 = Pharmacy to Pharmacy Transfer
15	Refill Number	O	T/M	ID	0/2	Sequential refill number submitted by the pharmacy: 00 = New Fill 01-99 = subsequent fills
16	General Text Message	O	M	AN	0/100	Claim record comment line.
17	Payment Batch Number	O	M	N0	0/10	Explanation of Benefits (EOB) Cycle Number.
18	Payment Batch Sub Number	O	M	N0	0/2	Explanation of Benefits (EOB) Sub Cycle Number - as used for daily EOB cycles.
19	Payment Batch Date	O	M	DT	0/8	Date of the Payment/EOB Cycle.
20	Paid Date	O	M	DT	0/8	Date of the check payment to the pharmacy or member. This value is not related to the invoice paid date for the plan.
21	Check reference number	O	M	N0	0/10	Identification number that references a pharmacy or member reimbursement for payment.
22	Decimal Quantity Dispensed	O	T/M	R3	0/15	Quantity of the product dispensed including decimal values. Value is as submitted by the vendor on the claim transaction.
23	Days supply	M	T/M	N0	1/10	Number of days the prescription should last. Based on number of doses per day and total number of doses.
24	Formulary Flag	O	P/M	ID	0/1	Product is on the formulary: Y = Is part of the formulary N = Is not part of the formulary O = Other - no formulary. For example, the transaction was adjudicated under a benefit that had no formulary

Ref	Element Name	Req	Src	Type	Min / Max	Comment
25	Unit Dose Indicator	O	T/M	ID	0/1	Unit Dose Indicator: 1 = Unit Dose 0 = All Other Products: Blank = Blank, N/A
26	Drug Group Report Code	O	M	ID	0/1	Drug Group Report Code: M = Medical P = Pharmacy V = Vaccine The value only populated if the appropriate configuration is established. Contact your client specialist for further information with respect to functionality and setup.
27	Submitted Route of Administration	O	T/M	ID	0/11	Submitted Route of Administration. This is the value as submitted on the transaction and may be different than the route of administration that is referenced in the Drug Product Information Segment - DRG. Per NCPDP external code list, value should be based on the SNOMED codes (Systematized Nomenclature of Medicine Clinical Terms®) - This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture. Terminology which is available from the International Health Terminology Standards Development Organization (IHTSDO) http://www.ihtsdo.org/snomed-ct
28	Compound Code	M	T/M	ID	1/1	Will contain the value: Blank, 0 or 1 = Non-compound 2 = Compound
29	Compound Ingredient Component Count	O	T/M	N0	0/2	Number of identified ingredients within the compound transaction. Count is only populated if the transaction is identified as a being a compound transaction. Ingredients associated with the drug compound are reported within the Drug Product Information segment (DRG).

Ref	Element Name	Req	Src	Type	Min / Max	Comment
30	Transmittal Number	O	P/M	ID	0/20	Transmittal number associated to the claim transaction. Only applies to manually entered paper claims transactions.
31	Billing Matrix Code	O	M	ID	0/20	Billing matrix code associated with the claim transaction.
32	Claim Type Charge	X	M	ID	0/1	Claim type charge flag: Y = POS, DMR or Paper fee was charged N = No POS, DMR or Paper fee was charged Field is only populated with a value if a value is defined in the Billing Matrix Code field. If the Billing Matrix Code field contains no value, this field is not populated.
33	Claim Process Charge	X	M	ID	0/1	Claim processing charge flag: Y = Processing fee was charged N = No processing fee was charged Field is only populated with a value if a value is defined in the Billing Matrix Code field. If the Billing Matrix Code field contains no value, this field is not populated.
34	Network Code	O	M	ID	0/30	Contains the network code that the transaction processed under.
35	Grace Period	O	P	AN	0/30	Captures the time period where a member is behind on premiums. May be required for POS adjudication. Starting date should be designated as the day after the last premium date: Y = Active grace period N = No coverage for the member during the grace period

Ref	Element Name	Req	Src	Type	Min / Max	Comment
36	PBM Program Number	O	M	N0	0/3	PBM Program associated to the claim: 9 = IRx Benefit

Notes

- Data Elements noted as mandatory may be blank for Denied Claims.

CLR - Claim Reject Information

Provides information on the reject reasons if the submitted claim transaction is denied/rejected

Ref	Element Name	Req	Src	Type	Min/Max	Comment
01	Reject Reason Sequence Number	M	M	N0	1/2	Sequence count on the reject code that is reported.
02	Reject Code	O	M	ID	0/5	Reject code.
03	Reject Code Description	O	M	AN	0/150	Contains the description of the reject code.
04	Message Field Code	O	M	AN	0/5	MedImpact internal error number.

Notes

- This segment is optional and only populated if the claim transaction rejected with a reason response.
- Either the reject code or the message field code would be referenced in the file.
- This segment can be repeated more than once in the output file if there is more than one reject to reference with this claim transaction.

CLA - Claim Association Information

Provides information on the claim transactions that the submitted claims transaction is associated to

Ref	Element Name	Req	Src	Type	Min/Max	Comment
01	Source Claim Identification	M	M	ID	0/20	When a transaction is associated with an existing transaction, the existing (or source) transaction will be populated. Only relates to adjustments or transactions where a service has been included with the dispensing of the product (wrap coverage) associated/group transactions together
02	Claim Association Type	M	M	ID	0/30	This value indicates the type of associated claim: EGWP = Employer Group Waiver Plan VACCINE_ADMIN = Vaccine Administration

Notes

- This segment is optional, and only populated if there is an associated claim referenced.
- Both fields are mandatory in the situation where the segment is reported.
- This segment can be repeated more than once in the output file if there is more than one source claim to reference with this claim transaction.

N51 - NCPDP 5.1 Specific Information

Details for the specific data fields submitted by the vendor that relates to fields that are NCPDP 5.1 specific

Ref	Element Name	Req	Src	Type	Min/Max	Comment
01	Eligibility Clarification Code	O	T/M	ID	0/1	Will contain the value: 0 = Not Specified 1 = No Override – Eligibility denial cannot be superseded 2 = Override – Eligibility denial is being superseded 3 = Full Time Student – A dependent child enrolled as a full time student at a school 4 = Disabled Dependent – A dependent, regardless of age, who is disabled 5 = Dependent Parent - A dependent who is the parent. 6 = Significant Other – Partner other than the spouse
02	Product/Service Identification Qualifier	M	M	ID	1/2	Will contain the value of **03** (National Drug Code).
03	Product/Service Identification	M	T/M	ID	1/20	Since 03 is the only supported code at this time, the field will contain the drug product ID (NDC Code) to NDC 11 format. For example. 01234567890 represents NDC 01234-5678-90 where 01234 indicate the maker, 5678 indicates the drug and 90 indicates the packaging.
04	Product/Service Name	M	M	AN	1/50	Since 03 is the only supported code at this time, the field will contain the drug name (Brand Name).

Ref	Element Name	Req	Src	Type	Min / Max	Comment
05	Prescription Denial Override # 1	O	T/M	ID	0/2	Rx denial clarification codes: 0, 00, or blank = Not specified 1 = No Override 2 = Other Override 3 = Vacation Supply 4= Lost Prescription 5 = Therapy Change 6 = Starter Dose 7 = Medically Necessary 8 = Process Compound for Approved Ingredients 9 = Encounters 10 = Meets Plan Limitations 11 = Certification on File 12 = DME Replacement Indicator 13 = Payer Recognized Emergency/Disaster Assistance Request 14 = Long Term Care Leave of Absence 15 = Long Term Care Replacement Medication 16 = Long Term Care Emergency box or Automated Dispensing Machine 17 = Long Term Care Emergency Supply Remainder 18 = Longer Term Care Patient Admit/Readmit Indicator 19 = Split Billing 99 = Other

Ref	Element Name	Req	Src	Type	Min / Max	Comment
06	Other Coverage Code	O	T/M	ID	0/1	Will contain the value: 0 = Primary 1 = Primary 2 = Payment by other insurer 3 = Rejected by other insurer 4 = No payment by other insurer, not rejected 5 = Manage care denial 6 = Not a participating provider 7 = No other coverage on date of service 8 = Copay only billing
07	Member Residence Code	O	T/M	ID	0/2	Patient Location Code: 0 = Not Specified 1 = Home 2 = Inter-Care 3 = Nursing Home 4 = Long Term/Extended Care 5 = Rest Home 6 = Boarding Home 7 = Skilled Care Facility 8 = Sub-Acute Care Facility 9 = Acute Care Facility 10 = Outpatient 11 = Hospice 12 = End Stage Renal Disease Treatment Facility

Notes

- This segment is only populated if the submitting claim transaction is processed under NCPDP 5.1 standards.

ND0 - NCPDP D.0 Specific Information

Details for the specific data fields submitted by the vendor that relates to fields that are NCPDP D.0 specific

Ref	Element Name	Req	Src	Type	Min/Max	Comment
01	Eligibility Clarification Code	O	T/M	ID	0/1	Will contain the value: 0 = Not Specified 1 = No Override – Eligibility denial cannot be superseded 2 = Override – Eligibility denial is being superseded 3 = Full Time Student – A dependent child enrolled as a full time student at a school 4 = Disabled Dependent – A dependent, regardless of age, who is disabled. 5 = Dependent Parent - A dependent who is the parent. 6 = Significant Other – Partner other than the spouse
02	Product/Service Identification Qualifier	M	M	ID	1/2	Will contain the value of **03** (National Drug Code).
03	Product/Service Identification	M	T/M	ID	1/20	Since 03 is the only supported code at this time, the field will contain the drug product ID (NDC Code) to NDC 11 format. For example. 01234567890 represents NDC 01234-5678-90 where 01234 indicate the maker, 5678 indicates the drug and 90 indicates the packaging. For compound transactions, this will be the primary drug product included in the compound.
04	Product/Service Name	M	M	AN	1/50	Since 03 is the only supported code at this time, the field will contain the drug name (Brand Name).

Ref	Element Name	Req	Src	Type	Min / Max	Comment
05	Prescription Denial Override # 1 (Submission Clarification Code # 1)	O	T/M	ID	0/2	Rx denial clarification code: 0, 00, or blank = Not specified 1 = No Override 2 = Other Override 3 = Vacation Supply 4= Lost Prescription 5 = Therapy Change 6 = Starter Dose 7 = Medically Necessary 8 = Process Compound for Approved Ingredients 9 = Encounters 10 = Meets Plan Limitations 11 = Certification on File 12 = DME Replacement Indicator 13 = Payer Recognized Emergency/Disaster Assistance Request 14 = Long Term Care Leave of Absence 15 = Long Term Care Replacement Medication 16 = Long Term Care Emergency box or Automated Dispensing Machine 17 = Long Term Care Emergency Supply Remainder 18 = Longer Term Care Patient Admit/Readmit Indicator 19 = Split Billing 21 = LTC dispensing: 14 days or less not applicable 22 = LTC dispensing: 7 days 23 = LTC dispensing: 4 days 24 = LTC dispensing: 3 days 25 = LTC dispensing: 2 days 26 = LTC dispensing: 1 day 27 = LTC dispensing: 4-3 days 28 = LTC dispensing: 2-2-3 days 29 = LTC dispensing: daily and 3-day weekend 30 = LTC dispensing: Per shift dispensing 31 = LTC dispensing: Per med pass dispensing 32 = LTC dispensing: PRN on demand 33 = LTC dispensing: 7-day or less cycle not otherwise represented 34 = LTC dispensing: 14 days dispensing 35 = LTC dispensing: 8-14 day dispensing method not listed above 36 = LTC dispensing: dispensed outside short cycle 99 = Other

Ref	Element Name	Req	Src	Type	Min / Max	Comment
06	Prescription Denial Override # 2 (Submission Clarification Code #2)	O	T/M	ID	0/2	See Prescription Denial Override # 1
07	Prescription Denial Override # 3 (Submission Clarification Code # 3)	O	T/M	ID	0/2	See Prescription Denial Override # 1
08	Other Coverage Code	O	T/M	ID	0/1	Will contain the value: 0 = Primary 1 = Primary 2 = Payment by other insurer 3 = Rejected by other insurer 4 = No payment by other insurer, not rejected 8 = Copay only billing

Ref	Element Name	Req	Src	Type	Min / Max	Comment
09	Patient Residence Code	O	T/M	ID	0/2	Will contain the value: 0 = Not specified 1 = Home 2 = Skilled nursing home 3 = Nursing facility 4 = Assisted living facility 5 = Custodial care facility 6 = Group home 9 = Intermediate care facility 15 = Correctional institute Values no longer supported under D.0: 7 = Inpatient Psychiatric facility 8 = Psychiatric facility - partial hospitalization 10 = Residential substance abuse treatment facility 11 = Hospice 12 = Psychiatric residential treatment facility 13 = Comprehensive inpatient rehabilitation facility 14 = Homeless shelter
10	Place of Service	O	T/M	ID	0/2	Contains the place of service code as submitted by the pharmacy on the claim transaction. There are now over 50 different code values that can be defined per the NCPDP standards. Ref to the NCPDP External Code List for complete details. If the value is blank or 0, the value has not been specified.
11	CMS Part-D Defined Qualified Facility	O	T/M	ID	0/1	At present, only for Part-D Long Term Care (LTC) transactions: Y = CMS Qualified Facility N = Not a Part-D Facility All other cases, no value reported.
12	Submitted RxBIN	O	T/M	ID	0/6	The submitted Banking Information Number that is used to identify the organization that the claim is to be routed to for processing.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
13	Submitted RxPCN	O	T/M	ID	0/6	The submitted Processor Control Number that is used to route the claim to a processing service within the identified organization. The first 5 digits of the RxPCN will be referenced.
14	Submitted RxGrp	O	T/M	ID	0/15	The submitted Group identifier to identify which health plan the transaction is for.
15	Special Packaging Indicator	O	T/M	ID	0/1	Code indicating the type of unit dose dispensing as submitted by the pharmacy: 0 or blank = Not Specified 1 = Not Unit Dose - Indicates the product is not being dispensed in special unit dose packaging 2 = Manufacturer Unit Dose - A code used to indicate a distinct dose as determined by the manufacturer 3 = Pharmacy Unit Dose – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was “loaded” at the pharmacy – not purchased from the manufacturer as a unit dose 4 = Pharmacy Unit Dose Patient Compliance Packaging – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly 5 = Pharmacy Multi-drug Patient Compliance Packaging - Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration 6 = Remote Device Unit Dose - Drug is dispensed at the facility, via a remote device, in a unit of use package 7 = Remote Device Multi- drug Compliance - Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration 8 = Manufacturer Unit of Use Package (not unit dose) - Drug is dispensed by pharmacy in original manufacturer’s package and relabeled for use

Notes

- This segment is only populated if the submitting claim transaction is processed under NCPDP D.0 standards.

PRV - Provider Information

Details the provider that is dispensing the product, and the provider that wrote out the prescription

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Submitted Vendor Qualifier	O	T/M	ID	0/2	Will contain the identification qualifier for the vendor dispensing the product. This can be any of the 15 qualifier codes enabled by NCPDP, but generally will contain the value of: 01 = National Provider Identification 07 = NCPDP Identification Value is as submitted by the vendor on the transaction.
02	Submitted Vendor Identification	O	T/M	ID	0/10	Will contain the identification for the vendor dispensing the product. Value is as submitted by the vendor on the transaction.
03	Vendor Name	O	M	AN	0/100	Name of the vendor (pharmacy).
04	Vendor Address 1	O	M	AN	0/80	Vendor address line 1.
05	Vendor Address 2	O	M	AN	0/80	Vendor address line 2.
06	Vendor City	O	M	AN	0/80	Vendor city.
07	Vendor State	O	M	AN	0/2	Vendor State.
08	Vendor Zip or Postal Code	O	M	AN	0/20	Vendor zip code.
09	Vendor County	O	M	AN	0/50	Vendor county.
10	Vendor Phone	O	M	AN	0/15	Primary phone number.
11	Vendor Fax	O	M	AN	0/15	Primary fax number.
12	Vendor Chain Identification	O	M	ID	0/10	Vendor chain identifier as assigned by MedImpact.
13	Vendor Chain Name	O	M	AN	0/40	Name associated with the chain identifier.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
14	Vendor Tax Identification	O	M	ID	0/20	Vendor tax identification. **Note:** This is the chain tax identification.
15	Vendor Medi-Cal Identification	O	M	ID	0/15	Vendor Medi-Cal identification.
16	Vendor Service Type	O	T/M	ID	0/2	NCPDP D.0 only. Will contain the value: 1 = Community/Retail Pharmacy Service 2 = Compounding Pharmacy Service 3 = Home Infusion Therapy Provider Service 4 = Institutional Pharmacy Service 5 = Long Term Care Pharmacy Service 6 = Mail Order Pharmacy Service 7 = Managed Care Organization 8 = Specialty Care Pharmacy Service 99 = Other

Ref	Element Name	Req	Src	Type	Min / Max	Comment
17	Submitted Prescriber Qualifier	O	T/M	ID	0/2	Will contain the identification qualifier for the prescriber that wrote the prescription. This can be any of the 15 qualifier codes enabled by NCPDP, but generally will contain the value of: 01 = National Provider Identification 12 = Drug Enforcement Agency Identification Other possible submitted values are: 02 = Blue Cross 03 = Blue Shield 04 = Medicare 05 = Medicaid 06 = Universal Patient Identification (UPIN) 07 = NCPDP Provider Identification 08 = State License as assigned and required by a State Board or other State regulatory agency 09 = CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) 10 = Health Industry Number (HIN) 11 = Federal Tax Identification 13 = State Issued (other) 14 = Plan Specific 99 = Other Identification Source
18	Submitted Prescriber Identification	O	T/M	ID	0/10	Will contain the identification for the prescriber that wrote the prescription.
19	Prescriber First Name	O	M	AN	0/50	Prescriber first name.
20	Prescriber Middle Initial	O	M	AN	0/1	Prescriber middle initial.
21	Prescriber Last Name	O	M	AN	0/50	Prescriber last name.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
22	Prescriber Address 1	O	M	AN	0/80	Primary address line 1 for the submitted prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.
23	Prescriber Address 2	O	M	AN	0/80	Primary address line 2 for the submitted prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.
24	Prescriber City	O	M	AN	0/80	Primary city for the submitted prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.
25	Prescriber State	O	M	AN	0/2	Primary state code for the submitted prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.
26	Prescriber Zip or Postal Code	O	M	AN	0/20	Primary zip code for the submitted prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.
27	Prescriber Phone	O	M	AN	0/15	Primary phone number for the submitted prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.
28	Prescriber Fax	O	M	AN	0/15	Primary fax number for the submitted prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.
29	Derived prescriber NPI	O	M	ID	0/10	Derived prescriber National Provider Identification. Only populated if transaction is submitted with a qualifier that is not NPI and a value can be located.
30	Derived prescriber DEA	O	M	ID	0/10	Derived prescriber Drug Enforcement Agency Identification. Only populated if transaction is submitted with a qualifier that is not DEA and a value can be located.
31	Prescriber Taxonomy Code	O	M	ID	0/10	Primary Taxonomy Code for the submitted prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.
32	Prescriber Taxonomy Description	O	M	AN	0/255	Primary Taxonomy description for the submitted prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
33	Prescriber Specialty Code	O	M	ID	0/30	Primary Specialty Code for the submitted prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.
34	Prescriber Specialty Description	O	M	AN	0/100	Primary Specialty description for the submitted prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.
35	Prescriber Practitioner Type	O	M	ID	0/50	Reported practitioner Type Code of the prescriber. Information is based on the data provided by MedImpact through it prescriber vendor feed.

Notes

- This segment is only populated if there is a provider submitted with the claim.

CST - Transaction Cost Information

Details costs associated with the transaction. Excludes member and individual ingredient costs.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Price Identifier	M	M	ID	3/6	Price Identification Code: STD PIF PLR
02	Total Ingredient Cost	M	M	R2	4/15	Calculated total ingredient cost.
03	Dispensing Fee	M	M	R2	4/15	Professional dispensing fee (fill fee).
04	Professional Service Fee	O	T/M	R2	0/15	Professional Service Fee. Additional service costs associated with the transaction.
05	Incentive fee	O	M	R2	0/15	Additional incentive fee paid to the vendor.
06	Billed Amount	M	T/M	R2	4/15	Amount billed or submitted by entity. This value will be the same for all price identification codes.
07	Total Cost	M	M	R2	4/15	Adjudicated product cost (allowed cost).
08	Paid Amount	M	M	R2	4/15	Actual pay amount after the member costs are applied. Difference owed to an entity based on the price identifier and billed to plan.
09	Tax Amount	O	M	R2	0/15	Tax amount.
10	Sum of Other Payer Amounts Paid	O	M	R2	0/15	The total sum of the amount paid by other insurers (recognized Other Payers).
11	Copay Billed	O	M	R2	0/15	Submitted by the pharmacy. Amount of copay billed for Coordination of Benefits, when COB Other Coverage Code = 8
12	Sum of all Part-D ingredient amounts	O	M	R2	0/15	For Part-D Compound transactions only. Calculated total ingredient cost for all qualifying Part-D ingredients within the compound.
13	LICS amount	O	M	R2	0/15	Part-D transactions only - Low InCome Subsidy (LICS) amount.
14	SPAP amount	O	M	R2	0/15	Part-D transactions only - State Pharmaceutical Assistance Program (SPAP) amount.
15	Gap amount	O	M	R2	0/15	Part-D transactions only - Gap discount amount.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
16	EGWP amount	O	M	R2	0/15	For Part-D transactions only participating in an Employer Group Waiver Plan (EGWP). Calculated cost amount from the claim that is associated with the Employer Group Waiver Plan
17	Submitted U&C amount	O	M	R2	0/15	Submitted by the pharmacy - Usual and Customary amount. This value will be the same for all price identification codes.
18	Pre-balanced Total Ingredient Cost	M	M	R2	4/15	Calculated ingredient cost of the claim transaction before any balance calculation logic is applied. Only populated if the claim balance logic was required to be applied. If no balance logic was applied, this field will be empty.
19	Pre-balanced Dispensing Fee	M	M	R2	4/15	Calculated dispensing fee (fill fee).of the claim transaction before any balance calculation logic is applied. Only populated if the claim balance logic was required to be applied. If no balance logic was applied, this field will be empty.
20	Pre-balanced Professional Service Fee	O	T/M	R2	0/15	Calculated professional service fee of the claim transaction before any balance calculation logic is applied. Only populated if the claim balance logic was required to be applied. If no balance logic was applied, this field will be empty.
21	Pre-balanced Incentive fee	O	M	R2	0/15	Calculated professional incentive fee of the claim transaction before any balance calculation logic is applied. Only populated if the claim balance logic was required to be applied. If no balance logic was applied, this field will be empty.
22	Pre-balanced Total Cost	O	M	R2	0/15	Calculated total cost of the claim transaction before any balance calculation logic is applied. Only populated if the claim balance logic was required to be applied. If no balance logic was applied, this field will be empty.
23	Secondary LICS Amt	O	M	R2	0/15	Part-D transactions only – Amount of Plan Cost-Sharing Subsequent to LICS Amount (Field # 13)

Ref	Element Name	Req	Src	Type	Min / Max	Comment

Notes

- This segment can be repeated more than once in the output file if more than one price identifier is utilized in the claims transaction and is to be reported based on the contract agreement with MedImpact.
- Transactions with a "reversal" status will have a negative amount in the assigned cost amount fields.
- Paid amount field balances to gross amount on check control totals. A sum of claims where status = 1, 3 or 4 or balances to "Total Due from Plan" on check control tables.
- If this is a NCPDP D.0 compound claim transaction, the costs reported are the total sum of the claim costs. Refer to segment DCT - Drug Cost Information - for a breakdown of costs per each ingredient.
- If this is a NCPDP D.0 COB claim transaction, the costs reported are based on the payments calculated for the MedImpact part of the claim transaction billing. Any other known payers and amounts are reported in segment COB - Coordination of Benefits.
- Pre-Balanced logic relates to the NCPDP transaction mandate that processes must provide a balanced transaction response back to the pharmacy. This may involve certain costs fields to be updated to ensure that the amount balances. The Pre-balanced fields provide the values before the pre-balance calculation logic was applied. This change does not alter or impact the way claims previously paid.

MST - Member Cost Information

Details costs associated to the member

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Dispense as Written (DAW) Code	O	T/M	ID	0/1	Dispense as written code as submitted on the claim: 0 = No DAW 1 = Physician DAW 2 = Patient DAW 3 = Pharmacy DAW 4 = No generic in stock 5 = Brand as generic 6 = Override 7 = Brand by law 8 = Generic not available 9 = Plan requests brand to be dispensed
02	Dispense as Written (DAW) Difference	O	M	R2	0/15	Penalty amount assessed to the member for choosing a branded drug when a generic was available. This will apply in certain DAW situations when the benefit setup is requested.
03	Total Member Costs	M	M	R2	0/15	Sum of all charges to the member (previously referenced as out of pocket).
04	Copay Amount	O	T/M	R2	0/15	Member co-payment on transaction.
05	Additional Copay Amount	O	M	R2	0/15	Member's additional copay amount.
06	Deductible Amount	O	M	R2	0/15	Amount of the transaction that is applied to the member's deductible.

Notes

- Transactions with a "reversal" status will have a negative amount in the assigned cost amount fields.
- Total Member Costs (Out of pocket) is defined as all portions of a claim that are the member's responsibility.
- If this is a NCPDP D.0 COB claim transaction, the costs reported are based on the payments calculated for the MedImpact part of the claim transaction billing. Any other known member costs are reported in segment COB - Coordination of Benefits.

DRG - Drug Product Information

Provides details of the product(s)/ingredient(s) associated with the transaction

Ref	Element Name	Req	Src	Type	Min/Max	Comment
01	Ingredient Sequence Number	M	T/M	N0	1/2	Sequence count on the number of products included in the report. If the claim is not a compound claim, only one instance of this segment will be included, with the value equal to 1.
02	Product/Service Identification Qualifier	M	M	ID	1/2	Will contain the value of **03** (National Drug Code).
03	Product/Service Identification	M	T/M	ID	1/20	Since 03 is the only supported code at this time, the field will contain the drug product ID (NDC Code) to NDC 11 format. For example. 01234567890 represent NDC 01234-5678-90 where 01234 indicate the maker, 5678 indicates the drug and 90 indicates the packaging.
04	Product/Service Name	M	M	AN	1/50	Since 03 is the only supported code at this time, the field will contain the drug name (Brand Name).
05	Metric Quantity Dispensed	O	T/M	R3	0/15	Quantity of the product dispensed.
06	Ingredient Type	O	M	ID	0/1	Only applicable if the claim transaction is a compound. P = Primary Ingredient I = Supporting ingredient **Note:** C values in a compound transaction are not included.
07	Generic Product Flag	O	M	ID	0/1	Will contain the value: 0 = Non-drug item 1 = Generic 2 = Brand Blank = Not specified Value is reported at the instance when the transaction is processed.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
08	Drug Category (Preferred Flag)	O	M	ID	0/1	Product Category: G = Generic P = Preferred N = Non-preferred S = Special O = Other (not specified)
09	Label Name	O	M	AN	0/30	Product label name consisting of product name, strength and dosage form.
10	Source Indicator	O	M	ID	0/1	Will contain the value: Blank or 0 = Unspecified 1 = Multiple sources 2 = Single source Value is reported at the instance when the transaction is processed.
11	TCC Standard Code	O	M	ID	0/2	Therapeutic (Standard) Class Code of the product.
12	TCC Standard Description	O	M	AN	0/30	Therapeutic (Standard) Class Code Description.
13	TCC Specific Code	O	M	ID	0/3	Therapeutic (Specific) Class Code of the product.
14	TCC Specific Description	O	M	AN	0/60	Therapeutic (Specific) Class Code Description.
15	AHFS Therapeutic Class Code	O	M	ID	0/8	American Hospital Formulary Service 8 digit Therapeutic Class Code.
16	AHFS Therapeutic Class Code Description	O	M	AN	0/30	AHFS description associated with the code.
17	Class Code	O	M	ID	0/1	Product class code: F = Federal Legend O = Over the counter
18	Self Injectable	O	M	ID	0/1	Self Injectable product indicator: Blank or N = No Y = Yes
19	Route Description	O	M	AN	0/10	Route of Administration description.
20	Dosage Form	O	M	AN	0/10	Dosage Form Description

Ref	Element Name	Req	Src	Type	Min / Max	Comment
21	Strength	O	M	AN	0/10	Strength Description
22	DEA Code	O	M	AN	0/1	Drug Enforcement Agency (DEA) classification code
23	Part-D Covered Y/N - Part-D Compounds only	O	M	ID	0/1	Part-D Compound transactions only. Notes if the product is covered or not.
24	Part-D Ingredient Type - Part-D Compounds only	O	M	ID	0/1	Part-D Compound transactions only. Notes the ingredient type: D = Part-D Drug B = Part-B Drug X = Excluded Drug E = Enhanced Drug O = Over The Counter (OTC) Drug
25	Reject Code - Part-D Compounds only	O	M	ID	0/3	Only applicable if this is a Part-D compound transaction. Code if ingredient is rejected. For Part-D all ingredients are analyzed and may contain a reject code. For non-Part-D, only the primary is reported
26	Reject Code Description - Part-D Compounds only	O	M	AN	0/50	Only applicable if this is a Part-D compound transaction. Reject Code Details
Sub Segment DCT - Drug Cost Information Provides cost details of the product or products associated with the reported drug						
01	Price Identifier	M	M	ID	3/6	Price Identification Code: STD PIF PLR
02	Ingredient Cost	M	M	R2	4/15	Calculated total cost for the specific product/ingredient. If this is not a compound claim transaction, this will equal the same value as the total ingredient cost in the Transaction Cost Information segment (CST).

Ref	Element Name	Req	Src	Type	Min / Max	Comment
03	Client pricing basis of cost	M	T/M	ID	0/2	Identifies the basis of the reimbursement rate that was used. Based on the NCPDP transaction element of with current applicable values per NCPDP are: Blank = Not Specified. 01 = Average Wholesale Price The current average wholesale price as provided by First DataBank, chaindrugstore.net or Medi-Span. 02 = Acquisition Cost (ACQ) Not currently supported by MedImpact. 03 = Manufacturer Direct Price Not currently supported by MedImpact. 04 = Federal Upper Limit (FUL) Not currently supported by MedImpact. 05 = Average Generic Price Not currently supported by MedImpact. 06 = Usual & Customary The pharmacy's price for the medication for a person paying cash on the day of dispensing. 07 = Submitted Ingredient Cost Not currently supported by MedImpact - utilize U&C. 08 = State MAC Not currently supported by MedImpact. 09 = Unit This will be the MAC (not State related), or other base unit price utilized by MedImpact. 10 = Usual & Customary or Copay Not currently supported by MedImpact.
04	Used Price Code	M	M	ID	0/10	Contains the used price code value. Refer to client specialist for further information on the code value assigned.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
05	Undiscounted Baseline unit price qualifier	O	M	ID	0/10	Will contain the value: AWPA AWPE
06	Undiscounted Baseline unit price amount	O	M	R5	0/15	Based on client selected pricing option is the baseline unit price of the product. For example, if the pricing option is AWPA, this will be the AWPA unit price. **Note:** The baseline price may not be reported if there is no active contract license with First Databank or Medi-Span.

Notes

- In the case of a compound transaction processed to NCPDP D.0 standards, the DRG segment can be repeated to include each ingredient. Field 01 provides the sequence/order of the ingredients. For each DRG segment, there is the corresponding Drug Cost Segment (DCT) reported. Therefore in the case of a 3 ingredient drug compound, the sequence of the segments would be DRG~DCT (Drug 1) ~DRG~DCT (Drug 2)~DRG~DCT (Drug 3).
- In the case of a compound transaction processed under the NCPDP D.0 standards, the total sum of all individual ingredient amounts may result in a slightly different amount that the total amount paid that is reported in the claim cost segment (CST). This is due to the calculation process that the point of sale system applies to balance to the claim transaction to NCPDP D.0 standards.
- In the case of a compound transaction processed under the NCPDP D.0 standards, the ingredient costs will not be calculated if the transaction is denied or reversed. The cost information in the cost segment should be utilized for any cost calculation processing based on the ingredient data.

COB - Coordination of Benefits

Details of other known payers and member costs identified with the transaction

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Coordination of Benefits/Other Payments Sequence Number	M	T/M	N0	1/2	Sequence count on the instance of the reporting of the other payments associated with the claim transaction.
02	Other Payer Coverage Type	O	T/M	ID	1/2	Coverage Type Code for the Other Payer: Blank = Not Specified 01 = Primary – First 02 = Secondary – Second 03 = Tertiary – Third 04 = Quaternary – Fourth 05 = Quinary – Fifth 06 = Senary – Sixth 07 = Septenary - Seventh 08 = Octonary – Eighth 09 = Nonary – Ninth

Ref	Element Name	Req	Src	Type	Min / Max	Comment
03	Other Payer ID Qualifier	O	T/M	ID	1/2	Qualifier code to identify the Other Payer Amount: 01 = National Payer ID-Code indicating that the information to follow is the National Payer Identifier mandated under HIPAA. This identification system is currently under development; therefore this Code is not in use. 1C = Medicare Number-A number that identifies the federal program providing health insurance for people aged 65 and older and for disabled people of all ages. 1D = Medicaid Number-A number that identifies a program, financed jointly by the federal government and the states, that provides health coverage for mostly low-income women and children as well as nursing-home care for low-income elderly. 02 = Health Industry Number (HIN)-A 9 digit alphanumeric number used to identify health care entities such as veterinarians, animal clinics, and health care provider facilities. The number is assigned by HIBCC. 03 = Bank Information Number (BIN) Card Issuer ID or Bank ID Number assigned by ANSI used for network routing. Now defined by ANSI as the Issuer Identification Number (IIN). This may also be the Processor ID, assigned by NCPDP. 04 = National Association of Insurance Commissioners (NAIC)-A unique number for each company that does business in the United States as assigned by NAIC. A company may have multiple NAIC Codes to represent subsidiary companies under a main company. 05 = Medicare Carrier Number–A number assigned by the carrier or intermediary which administers the Medicare health insurance 99 = Other-Different from those implied or specified.
04	Other Payer ID	O	T/M	ID	1/10	Identification of the Other Payer.
05	Other Payer Date	O	T/M	DT	8/8	Date of when the other paid amount was paid.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
Sub-Segment CBD - Coordinate of Benefits - Other Payer Amount Paid						
Provides paid amount details for the other payer						
01	Other Payer Amount Paid Qualifier	O	T/M	ID	1/2	Qualifier code to identify the Other Payer Amount Paid: 01 = Delivery – An indicator which signifies the dollar amount paid by the other payer which is related to the delivery of a product or service. 02 = Shipping – An indicator which signifies the dollar amount paid by the other payer which is related to the transportation of a product. 03 = Postage – An indicator which signifies the dollar amount paid by the other payer which is related to the mailing of a product. 04 = Administrative – An indicator which signifies the dollar amount paid by the other payer which is related to administrative activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance. 05 = Incentive-An indicator which signifies the dollar amount paid by the other payer which is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g. collection of survey data, counseling plan enrollees, vaccine administration). 06 = Cognitive Service – An indicator which signifies the dollar amount paid by the other payer which is related to the pharmacist's interaction with a patient or caregiver that is beyond the traditional dispensing/patient instruction activity (e.g. therapeutic regimen review; recommendation for additional, fewer or different therapeutic choices). 07 = Drug Benefit – An indicator which signifies the dollar amount paid by the other payer which is related to the plan's drug benefit. 09 = Compound Preparation Cost – An indicator which signifies the dollar amount paid by the other payer which is related to the preparation of the compound. 10 = Sales Tax - An Indicator which signifies the dollar amount.
02	Other Payer Amount Paid	O	T/M	R2	0/15	Other payer amount paid.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
Sub-Segment CBP - Coordination of Benefits – Patient Responsibility Details of the patients' responsibility amounts						
01	Other Payer-Patient Responsibility Amount Qualifier	O	T/M	ID	1/2	Qualifier code to identify the Other Payer Patient Responsibility Amount: Blank = Not Specified 01 = Amount Applied to Periodic Deductible as reported by previous payer. The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. 02 = Amount Attributed to Product Selection/Brand Drug as reported by previous payer. 03 = Amount Attributed to Sales Tax as reported by previous payer. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. 04 = Amount Exceeding Periodic Benefit Maximum as reported by previous payer. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. 05 = Amount of Copay as reported by previous payer. Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. 06 = Patient Pay Amount as reported by previous payer. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. 07 = Amount of Coinsurance as reported by previous payer. Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. 08 = Amount Attributed to Product Selection/Non-Preferred Formulary Selection. 09 = Amount Attributed to Health Plan Assistance Amount as reported by previous payer 10 = Amount Attributed to Provider Network Selection as reported by previous payer. 11 = Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection as reported by previous payer. 12 = Amount Attributed to Coverage Gap that was to be collected from the patient due to a coverage gap as reported by previous payer. 13 = Amount Attributed to Processor Fee as reported by previous payer.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
02	Other Payer-Patient Responsibility Amount	O	T/M	R2	0/15	Patient responsibility amount.
Sub-Segment CBS - Coordination of Benefits –Benefit Staging Details of other known payers and member costs identified with the transaction						
01	Benefit Stage Qualifier	O	T/M	ID	0/2	When applicable (Part-D transactions only), will contain the value: 01 = Deductible - The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer 02 = Initial Benefit - The first monthly benefit, or the first monthly benefit following any break in participation 03 = Coverage Gap (donut hole) - Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MA-PD, after the initial coverage limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount 04 = Catastrophic Coverage - Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year 50 = Not paid under Part D, paid under Part C benefit (for MA-PD plan) 60 = Not paid under Part D, paid as or under a supplemental benefit only 70 = Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing 80 = Non-Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing
02	Benefit Stage Amount	O	T/M	R2	0/15	When applicable (Part-D transactions only), will contain the value allocated from the claim transaction that was allocated to the Medicare state as identified by the “Benefit Stage Qualifier”.
Sub-Segment CBR - Coordination of Benefits - Reject Details any rejects based on the submission of the Other Payer information within the Coordination of Benefits segment (COB)						
01	Other Payer Reject Count	M	T/M	N0	0/2	Sequence count on the instance of the reporting of the Other Payer Reject code. More than one reject code can be submitted per each Other Payer submission.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
02	Other Payer Reject Code	M	T/M	ID	0/3	Reject code on the submitted Other Payer Amount

Notes

- This segment is only included if the submitted claim transaction is processed under the NCPDP D.0 standards and the transaction is a Coordination of Benefits transaction.
- This segment can be repeated based on the number of payers identified.
- The structure of the COB segment is that the COB segment is always included to outline the identified or submitted payer, and either contains the Other Payer Amounts (CBD), the Other Payer Patient Responsibility Amounts (CBP), or the Reject (CBR) sub-segment per payer. Only in selected circumstances based on the data submitted on the claim transaction would the CBD and CBP sub-segments be included together for an identified payer.
- The reject sub-segment can be repeated more than once for the identified payer if more that one rejection is triggered.
- The Benefit Staging (CBS) sub-segment is included per identified payer if the transaction is a Part-D transaction.

PAN - Prior Authorization Information

Details for the submitted prior authorization that is associated with the transaction

Ref	Element Name	Req	Src	Type	Min/Max	Comment
01	Approval Number	M	M	N0	0/11	Prior Authorization Number.
02	PA Type Code	M	M	ID	0/2	PA Type Code: 0 = Not Specified 1 = Prior Authorization 2 = Medical Certification 3 = Early Periodic Screening Diagnosis Treatment (EPSDT) 4 = Exemption From Copay 5 = Exemption From Prescription 6 = Family Plan 7 = Aid to Families With Dependent Children (AFDC) 8 = Payer Defined Exemption
03	Submitted PA Code Number	O	T/M	N0	0/11	PA Code Number as submitted in the transaction.
04	PA Status Code 1	O	M	ID	0/5	PA Status Code #1.
05	PA Status Code 2	O	M	ID	0/5	PA Status Code #2.
06	PA Status Code 3	O	M	ID	0/5	PA Status Code #3.

Notes

- This segment is only included if a Prior Authorization is associated with the transaction.

PRD - Part-D Specific Information

Part-D specific information associated with Part-D transactions

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Part-D Type Indicator	O	M	ID	0/1	Will contain the value: D = Part-D O = Over The Counter (OTC) E = Enhanced Blank = Not Applicable
02	Member LICS Level Number	O	M	ID	0/1	Low Income Subsidy (LICS) cost sharing level.
03	Carrier CMS Part-D Code	O	M	ID	0/1	Used by invoicing to determine whether or not the claim is Part-D: Blank = Commercial All other values = Part-D
04	RDS Part-D Indicator	O	M	ID	0/1	Provides the Retiree Drug Subsidy Part-D Indicator: D = Part-D Drug B = Part-B Drug X = Excluded Drug E = Enhanced Drug O = Over The Counter (OTC) Drug Contact your client specialist for further information with respect to functionality and setup.
05	CMS Coverage Level Indicator	M	M	ID	1/3	CMS coverage level type for the transaction: I = Initial Coverage Level) G = G Gap Coverage C = Catastrophic A = Attachment Point met after Catastrophic has been reached If the claim meets more than one coverage type, each level will be referenced (for example IG).

Ref	Element Name	Req	Src	Type	Min / Max	Comment
06	CMS Contract ID	M	P	ID	1/8	Identifies the Plan and should be populated with the five-character alphanumeric H#, R#, S#, E#, or F# assigned by CMS.
07	CMS Plan ID	M	P	ID	1/8	Identifies the specific PBP within a contract.
08	Health Insurance Claim Number	M	P	ID	1/20	The beneficiary's Medicare identification number (HIC No)
09	Benefit Stage Count	M	M	N0	0/2	Count of 'Benefit Stage Amount' occurrences. Number of entries within the BSA segment
Sub-Segment BSA - Benefit Staging Amounts Captures the benefit stage amounts - will repeat for each identified stage amount						
01	Benefit Stage Qualifier	M	M	AN	0/2	Code qualifying the Benefit Stage Amount: 01 = Deductible - The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer 02 = Initial Benefit - The first monthly benefit, or the first monthly benefit following any break in participation 03 = Coverage Gap (donut hole) - Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MA-PD, after the initial coverage limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount 04 = Catastrophic Coverage - Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year 50 = Not paid under Part D, paid under Part C benefit (for MA-PD plan) 60 = Not paid under Part D, paid as or under a supplemental benefit only 70 = Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing 80 = Non-Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing

Ref	Element Name	Req	Src	Type	Min / Max	Comment
02	Benefit Stage Amount	M	M	R2	0/15	Will contain the value allocated from the claim transaction that was allocated to the Medicare state as identified by the “Benefit Stage Qualifier”.

Notes

- This segment is only included if the transaction is identified as a Part-D transaction.

SE - Transaction Set Trailer

To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

Ref	Element Name	Req	Src	Type	Min/Max	Comment
01	Number of Included Segments	M	M	N0	1/10	Total number of segments included within the file. Sum includes both the Header and Trailer segments.
02	Transaction Set Control Number	M	M	AN	4/9	Equals the job ID assigned by the file extraction program.
03	Total Sum of Paid Amount	M	M	R2	4/25	Additional file check that totals the sum of the Paid Amount field for all transactions included within the file. Sum is based on field 08 (Paid Amount) within the Cost Information Segment (CST) for all claim transactions marked with price code of standard (STD).

Notes

- For Element *Number of Included Segments*, this will be the number of segments included in the transmission including both the Header (ST) and Trailer (SE) Segments.

Additional Information

• Record Information Structure

- **Ref = Field Reference Number**
  Identifies the data element number within the file segment.

- **Element Name**
  Provides the name of data element.

- **Req = Required File Definition**
  M = Mandatory
  The designation of mandatory is absolute in the sense that there is no dependency on other data elements.
  O= Optional
  The designation of optional means that there is no requirement for a data element to be present in the segment.
  X= Relational
  Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition of the affected data elements. A data element may be subject to more than one relational condition.

- **Src = Source of the information**
  M = MedImpact
  The information is derived by MedImpact, or is based on information that MedImpact has obtained through external data sources that is not health plan that the transaction is associated to.
  P = Health Plan
  Information is based on information MedImpact has received from the Health Plan (or client).
  T = Transaction
  Information is based on the information as submitted on the transaction that MedImpact received.
  T/M = Transaction or MedImpact
  Depending on the type of transaction, the information is either derived by MedImpact, or is as submitted on the transaction. For example, transactions received electronically through the Point of Sale system will utilize the information as submitted on the transaction, yet for a paper claim transaction processed through the Point of Sale system the information would be entered by a MedImpact data entry specialist (or external data entry specialist that is handling paper claims for a client).
  P/M = Health Plan or MedImpact
  Depending on the type of transaction, the information is either derived by MedImpact, or provided by the Health Plan. For example, Group identifiers can be provided by the Health Plan through the eligibility data feeds, or derived by MedImpact.

- **Type = Data Type of the Field Element**

  N0 = Positive signed numerical value

  Value does not contain decimal values or leading zeros. The information is left-justified.

  Rx = Decimal value with an explicit decimal point included

  The value noted in the 'x' is the number of digits after the decimal, which are always populated even if the value is zero (0). Negative amounts with contain the negative sign '-' in the first position of the field (left side).

  ID = Identifier and identification values

  Generally, the values tie to a base listing of assigned values or codes. The format of the ID is the same as AN.

  AN = Alphanumeric/String

  The information is left-justified. Should the value of the field contain a system character, for example a pipe "|"or a tilde "~" symbol, the program generating the output file will convert this to a blank space.

  DT = Date

  Format CCYYMMDD, in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31).

  TM = Time

  Expressed in 24-hour clock time as follows: HHMMSS, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59).

- **Min/Max = Minimum and Maximum Length of the Data Element**

  Provides the minimum and maximum length of the field. A minimum field size of zero (0) means that there if there is no data to include, and the data element will only contain the end of field identifier.

- **Comment = Field Reference Number**

  Provides supporting details and comments of the field data element.

- ## File Configuration

  The claims transaction information is grouped by the Client HQ Code followed by the Transaction Identification (Claim ID), which is Field # 1 in the CLM Segment.

  The header line consists of the ST, BGN and N1 segments. The trailer line consists of the SE segment. All other segments within the file represent a detailed record, with each line containing a single claim transaction. Each segment is started with the segment identification code, with each field separated by the pipe "|" symbol. A tilde "~" symbol marks the end of the segment. A 'terminating pipe' delimiter will follow the last field in each segment. A new line <LF> symbol is included at the end of each line of the file.

- ## Job Scheduling

  The scheduling of the program to generate this file can be run only if the **recipient** has been configured within the ***CLIENT PROCESS PARAMETERS*** utility. The minimum requirement to receive the file is to have setup an HQ Header or HQ Code, the standard segment activated and the associated Recipient(s) values. In addition, recipients can be configured to receive Supplemental Segments as well as additional Cost Information data (PIF and/or PLR) based on the service level agreement.

Supporting Segment Details

The supporting segments are optional and included in the data extract based on the client configuration. The segments are included in the file after the standard segments. If subscription to a segment is not defined, the information will not appear in the output file (i.e. segment will not be present). Please contact your client team specialist for further information with respect to the supporting data segments.

FDB - Drug Product Information - First DataBank Specific

Details of the product associated with the transaction. Information is based on the data provided by First DataBank

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Ingredient Sequence Number	M	T/M	N0	1/2	Will contain the count of the ingredient. If this is a single ingredient transaction, will contain the value '1'. If a compound transaction, value will represent the ingredient count within the submitted claim transaction.
02	Generic Code Number	M	M	ID	0/5	Generic product identification number.
03	Smart Key HICL	O	M	ID	0/5	Product Smart Key HICL Code.
04	Smart Key HICL Description	O	M	AN	0/50	Product Smart Key HICL Code description.
05	Smart Key GTC Code	O	M	ID	0/2	Smart Key Generic Therapeutic Code.
06	Smart Key GTC Code Description	O	M	AN	0/50	Smart Key Generic Therapeutic Code description.
07	Smart Key STC Code	O	M	ID	0/4	Smart Key Specific Therapeutic Code.
08	Smart Key STC Code Description	O	M	AN	0/50	Smart Key Specific Therapeutic Code description.
09	Dosage Form Code	O	M	ID	0/1	Dosage Form Code. Description is referenced in the Drug Product Information segment DRG.
10	Generic Sequence Number	O	M	ID	0/6	Generic sequence number that identifies the clinical formulation.

Notes

- If the claim transaction is NCPDP D.0 compound transaction, the segment is repeated for each product.
- This segment is only available to clients that have an active data subscription with FDB. The data segment contains values that are proprietary to FDB, and can only be published to receivers that also have an active subscription.

DRP - Drug Program Information

Details further information with respect to supported drug programs implemented with MedImpact, such as 340B.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Drug Program Code	M	M	ID	0/20	Indicates the type of price program: Blank = No price program 340B = 340B
02	Drug Program Patient Type	M	M	ID	0/10	Type of member eligibility: MEMBER = Health insurance with a MedImpact client, with an add-on 340B program. CASH = No health insurance
03	Drug Program Price Code	M	M	ID	0/20	Price code used to calculate the Drug Program Ingredient Cost.
04	Drug Program Applied Price Type	O	M	ID	0/20	Indicates which price type was the lowest and used to pay the transaction: SUBMITTED = Price as submitted on the transaction (Usual and Customary) NETWORK = Network negotiated price 340B = 340B Price
05	Drug Program Savings Amount	O	M	R2	0/15	Calculated savings amount using Drug Program versus Network or Usual and Customary (U&C).
06	Drug Program Ingredient Costs	O	M	R2	0/15	Calculated drug program ingredient cost.
07	Drug Program Fill Fee	O	M	R2	0/15	Drug program fill fee.
08	Drug Program Administration Fee	O	M	R2	0/15	Drug program administration fee.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
09	Drug Program Third Party Fee	O	M	R2	0/15	Drug program third party fee.
10	Drug Program Third Party Charge	O	M	R2	0/15	Drug program third party charge.
11	Admin Fee for claim where the Network price is lowest	O	M	R2	0/15	Admin Fee for claim where the Network price is lowest.
12	Admin Fee for claim where the Submitted price is lowest	O	M	R2	0/15	Admin Fee for claim where the Submitted price is lowest.
13	Service fee for claim	O	M	R2	0/15	Service fee for claim, for example service fee for 340b claim.

Notes

- This segment is only included if the transaction is associated to a Drug Program.
- This segment can be repeated if the transaction has more than one identified Drug Program Code.

MSP – Medi-Span Information

Details of the product associated with the transaction. Information is based on the data provided by Medi-Span

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Ingredient Sequence Number	M	T/M	N0	1/2	Will contain the count of the ingredient. If this is a single ingredient transaction, will contain the value '1'. If a compound transaction, value will represent the ingredient count within the submitted claim transaction.
02	GPID 14	O	T/M	ID	0/14	Medi-Span GPI 14 value for the NDC. May not be available for all NDC

Notes

- If the claim transaction is NCPDP D.0 compound transaction, the segment is repeated for each product.
- This segment is only available to clients that have an active data subscription with Medi-Span. The data segment contains values that are proprietary to Medi-Span, and can only be published to receivers that also have an active subscription.
- The information is only included if the corresponding NDC is part of the information delivered by Medi-Span.

MSS - Medicaid Subrogation Services Information

Provides details on the subrogation transaction

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Medicaid Member Identification Number	M	T/M	ID	1/20	The member's Medicaid ID number.
02	Medicaid Agency Identification Number	M	M	ID	1/30	Medicaid agency identification. MedImpact may receive the identification number associated with the agency in this field.
03	Medicaid Agency Name	M	M	AN	1/50	Name of the entity the subrogation payment is associated with.
04	Medicaid Claim Identification	M	T/M	ID	1/20	Represents the unique processing identification number assigned to this transaction by the original processor.
05	Medicaid Paid Amount	M	T/M	R2	4/15	Represents the amount for which the Medicaid Agency is requesting to be reimbursed.

Notes

- This segment is only available to clients that have subscribed to MedImpact's subrogation services. Please contact your client specialist for further information.
- All fields are mandatory when this segment is reported. If the claim transaction is not a subrogation transaction, this segment is not included for that transaction.

PDE - Calculated Prescription Drug Event Information

For Part-D transactions only. Provides a calculated incremental snapshot on how the claim transaction will update the amounts covered as part of the claims reporting to CMS (PDE reporting). The information should only be used for predictive analysis only, with actual amounts being reviewed from data generated from the PDE tool and accessible through the DDPS file that is provided from CMS.

Ref.	Element Name	Req	Src	Type	Min / Max	Comment
01	GDCB Out-of-Pocket Threshold Amount	M	M	R2	4/15	Gross drug cost below (GDCB) the catastrophic coverage threshold amount The actual dollar amount when the beneficiary is at or **below** the out-of-pocket (OOP) threshold and the drug is a covered Part D Drug. Otherwise it is zero.
02	GDCA Out-of-Pocket Threshold Amount	M	M	R2	4/15	Gross drug cost above (GDCA) the catastrophic coverage threshold amount The dollar amount that the beneficiary is **above** the Out of Pocket Threshold when the drug is a covered Part D Drug. Otherwise zero.
03	Other Troop Amount	M	M	R2	4/15	The dollar amount paid on behalf of the beneficiary by third party true out of pocket (TrOOP) eligible payers.
04	PLRO Due to Other Payer Amount	M	M	R2	4/15	Patient liability reduction due to other (non-TrOOP) payer's amount. The dollar amount paid by entities that reduce patient liability/cost, but do **not** count as TrOOP.
05	Covered Plan Paid Amount	M	M	R2	4/15	The net amount the plan paid for a covered Part-D drug under the defined standard benefit. If the drug coverage status code is coded "E" or "O", then this field is zero.
06	Non-Covered Plan Paid Amount	M	M	R2	4/15	The net amount the plan paid for benefits beyond the standard/basic benefit. This dollar amount should include non Part-D drugs, OTC products, EA products and EA cost-sharing.

Notes

- Transactions with a "reversal" status will have a negative amount in the assigned cost amount fields.
- Adjustment transactions will not be reported within this segment.
- Non Part-D claim transactions are not reported within this segment.

DST - Denied Transaction Cost Information

Details predictive claims costs associated with a denied transaction. It does not represent the final amounts that were reimbursed to the vendor.

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Price Identifier	M	M	ID	3/6	Price Identification Code: STD PIF PLR
02	Total Ingredient Cost	M	M	R2	4/15	Calculated total ingredient cost.
03	Dispensing Fee	M	M	R2	4/15	Professional dispensing fee (fill fee).
04	Professional Service Fee	O	T/M	R2	0/15	Professional Service Fee. Additional service costs associated with the transaction.
05	Incentive fee	O	M	R2	0/15	Additional incentive fee paid to the vendor.
06	Billed Amount	M	T/M	R2	4/15	Amount billed or submitted by entity. This value will be the same for all price identification codes.
07	Total Cost	M	M	R2	4/15	Adjudicated product cost (allowed cost).
08	Paid Amount	M	M	R2	4/15	Actual pay amount after the member costs are applied. Difference owed to an entity based on the price identifier and billed to plan.
09	Tax Amount	O	M	R2	0/15	Tax amount.
10	Sum of Other Payer Amounts Paid	O	M	R2	0/15	The total sum of the amount paid by other insurers.
11	Copay Billed	O	M	R2	0/15	Submitted by the pharmacy. Amount of copay billed for Coordination of Benefits, when COB Other Coverage Code = 8
12	LICS Amt	O	M	R2	0/15	Part-D transactions only - Low InCome Subsidy (LICS) amount.
13	SPAP Amt	O	M	R2	0/15	Part-D transactions only - State Pharmaceutical Assistance Program (SPAP) amount.
14	Gap Amt	O	M	R2	0/15	Part-D transactions only - Gap discount amount.
15	EGWP amount	O	M	R2	0/15	Part-D transactions only - Employer Group Waiver Plan (EGWP) amount.

Ref	Element Name	Req	Src	Type	Min / Max	Comment

Notes

- This segment, if requested, reports the predictive amounts that a claim may have paid if approved. If should be used for predictive analysis only and not applied as the actual. The claim could deny at any stage during the adjudication process, which meant that not all steps in the adjudication process has been applied to provide a final amount.
- This segment can be repeated more than once in the output file if more than one price identifier is utilized in the claims transaction and is to be reported based on the contract agreement with MedImpact.
- If this is a NCPDP D.0 compound claim transaction, the costs reported are the total sum of the claim costs.
- If this is a NCPDP D.0 COB claim transaction, the costs reported are based on the payments calculated for the MedImpact part of the claim transaction billing.

MSC - Member Miscellaneous Code Information

Member Miscellaneous Code details

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Miscellaneous Code 1	O	P	AN	0/10	Member Miscellaneous Code 1
02	Miscellaneous Code 2	O	P	AN	0/10	Member Miscellaneous Code 2
03	Miscellaneous Code 3	O	P	AN	0/10	Member Miscellaneous Code 3
04	Miscellaneous Code 4	O	P	AN	0/20	Member Miscellaneous Code 4
05	Miscellaneous Code 5	O	P	AN	0/10	Member Miscellaneous Code 5
06	Miscellaneous Code 6	O	P	AN	0/10	Member Miscellaneous Code 6
07	Miscellaneous Code 7	O	P	AN	0/10	Member Miscellaneous Code 7
08	Miscellaneous Code 8	O	P	AN	0/10	Member Miscellaneous Code 8
09	Miscellaneous Code 9	O	P	AN	0/10	Member Miscellaneous Code 9
10	Miscellaneous Code 10	O	P	AN	0/10	Member Miscellaneous Code 10
11	Miscellaneous Code 11	O	P	AN	0/10	Member Miscellaneous Code 11
12	Miscellaneous Code 12	O	P	AN	0/10	Member Miscellaneous Code 12

Notes

INV - Invoice Information

Provides detail drug cost information to be able to match the claim to the Drug Spend Cost of the Clients MedImpact invoice

Ref	Element Name	Req	Src	Type	Min / Max	Comment
01	Invoiced Transaction ID	M	M	ID	1/20	Transaction Identification generated when the transaction is received (also known as Claim ID).
02	Invoiced Pay-line Code	M	M	ID	3/6	The pay-line that was used to calculate the drug spend cost on the invoice - STD or PLR (if PLR is applicable).
03	Invoiced Drug Spend Cost	M	M	R2	4/15	Amount that will be invoiced. Actual pay amount after the member pay-line costs are applied.
04	Invoice Indicator	O	M	AN	1/10	Identifies if the claim transaction is part of the invoiced drug spend cost amount on the invoice or is for reference only as in the case for client owned pharmacies. Y = Check remittance is maintained by MedImpact N = Check remittance is not maintained by MedImpact
05	Member Pay Line Cost	M	M	R2	4/15	Amount that the member pays to determine the invoiced drug spend cost. This amount is different than the Total Member Cost as DAW penalty (DAW Diff) amount is not included.
06	Total Gross Drug Spend Cost	M	M	R2	4/15	Total cost amount plus tax amount for the invoiced pay-line before member pay line cost is deducted
07	Invoiced Pay-line Cost Based Upon Pharmacy Billed Amount Indicator	M	M	AN	1/1	Indicator to not if total cost before tax was based upon the pharmacy billed amount. If the billed amount is equal to or less than the total cost of the reported pay-line then the indicator will be Y (Yes), otherwise N (No).

Notes

- This segment will only be populated for the following status codes: APPROVED, RDA, RDP, RLA and RLP.
- Reversal claims RLP and RLA will display the referenced Approved claims Cost fields multiplied by * -1

HIX – Health Insurance Marketplace Information

Provides information related to Health Insurance Marketplace

Ref	Element Name	Req	Src	Type	Min/Max	Comment
01	Issuer ID	M	P	AN	0/5	Issuer Identification. Position 1-5 of the standard component ID generated by CMS.
02	State ID	M	P	AN	0/2	Two Digit State Code. Position 6-7 of the standard component ID generated by CMS.
03	Product Number	M	P	AN	0/3	Three Digit Product Number. Position 8-10 of the standard component ID generated by CMS.
04	Component Number	M	P	AN	0/4	Four Digit Standard Component Number. Position 11-14 of the standard component ID generated by CMS.
05	Variant	M	P	AN	0/2	Two Digit Variant Number. Position 15-16 of the standard component ID generated by CMS.
06	Qualified Health Plan ID	M	P	AN	0/16	Qualified Health Plan ID (QHP). Combined from the fields 01-05.
07	Market Type	M	P	AN	0/30	Valid Values are: INDIVIDUAL, SHOP, OTHER, COOP
08	Plan Type	M	P	AN	0/30	Valid Values are: HMO, PPO, POS, EPO, INDEMNITY
09	Coverage Level	M	P	AN	0/30	Coverage Level Type. Valid Values are: BRONZE, SILVER, GOLD, PLATINUM, CATASTROPHIC
10	Health Insurance Marketplace Group Indicator	M	P	AN	0/30	Assigned to Groups that are Health Insurance Marketplace groups. Valid Values are: “O” = On the Exchange, null
11	Unique Subscriber ID	O	P	AN	0/30	Exchange Assigned Identification, or Assigned Identification that uniquely identifies the subscribing member
12	Unique Member ID	O	P	AN	0/30	Exchange Assigned Identification, or Assigned Identification that uniquely identifies the member (non-subscriber)

Notes

- *This segment will be included for clients participating in Health Insurance Marketplace*