EXTERNAL CODE LIST

This document provides the code values for data elements contained within the NCPDP standards. The values support the various file and telecommunications formats that have been approved by the NCPDP membership.

June 2ØØ8

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NCPDP

EXTERNAL CODE LIST

NCPDP recognizes the confidentiality of certain information exchanged electronically through the use of its standards. Users should be familiar with the federal, state, and local laws, regulations and codes requiring confidentiality of this information and should utilize the standard accordingly.

NOTICE: In addition, this NCPDP Standard contains certain data fields and elements that may be completed by users with the proprietary information of third parties. The use and distribution of third parties' proprietary information without such third parties' consent, or the execution of a license or other agreement with such third party, could subject the user to numerous legal claims. All users are encouraged to contact such third parties to determine whether such information is proprietary and if necessary, to consult with legal counsel to make arrangements for the use and distribution of such proprietary information.

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I. INTRODUCTION

A. SECTION II OVERVIEW

Presented in Section II of this document are the values associated with the data elements that have been defined and approved by the National Council for Prescription Drug Programs membership The values support the data elements within the NCPDP approved standards.

Section II contains the alphabetical listing of NCPDP data elements contained in the External Code List. The definition of the field and the field format are listed. The NCPDP standard or version formats are listed. Under the column of "Field Limitations" notations such as "Value "X" may not be used in Telecommunication Standard VX.X or Lower" may be used. Each data element contains a listing of the codes and a description.

Example:

548-6F - Approved Message Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Message code, on an approved claim/service, communicating the need for an additional follow-up.	x(3)	T	

Values:

CODE	DESCRIPTION
Blank	Not Specified
ØØ1	Generic Available-Message from Processor to the pharmacist that a generic equivalent product is available when a claim is submitted for a brand-name product.
ØØ2	Non-Formulary Drug- Response code indicating that the prescribed drug is not included in the plan formulary.
ØØ3	Maintenance Drug –Medication used to control the symptoms of a chronic condition.
ØØ4	Filled During Transition Benefit
ØØ5	Filled During Transition Benefit/Prior Authorization Required
ØØ6	Filled During Transition Benefit/Non-Formulary
ØØ7	Filled During Transition Benefit/Other Rejection
ØØ8	Emergency Fill Situation
ØØ9	Emergency Fill Situation/Prior Authorization Required
Ø1Ø	Emergency Fill Situation/Non-Formulary
Ø11	Emergency Fill Situation/Other Rejection
Ø12	Level of Care Change
Ø13	Level Of Care Change/ Prior Authorization Required
Ø14	Level Of Care Change /Non-Formulary
Ø15	Level Of Care Change /Other Rejection

B. SECTION III OVERVIEW

Section III of this document provides a list of all data elements and associated values used in the SCRIPT Standard. Subsection A contains the NCPDP-created data elements. Subsection B contains the ASC X12 data elements. Subsection C contains the UN/EDIFACT data elements. The definition of the field and the field format are listed. The NCPDP standard or version formats are listed. Under the column of "Field Limitations" notations such as "Value "X" may not be used in SCRIPT Standard VX.X or Lower" may be used. Each data element contains a listing of the codes and a description.

Example:

4343 – Message Function, coded

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used in Prescription Change Request transactions, to request a change to the original new prescription.	an..3	S	

Values:

CODE	DESCRIPTION
G	Generic Substitution
T	Therapeutic Interchange/Substitution
P	Prior Authorization Required
A	Admit
C	Change
C1	Significant change (Any changes to the Drug, form, strength, dosage, or route)
C2	Frequency Change (Any change to the frequency or hours of administration for the drug)
C3	Insignificant Change (All other changes)
D1	Discharge – Expired
D2	Discharge – Return Not Anticipated
D3	Discharge – Return Anticipated
D4	Discharge Other

C. SECTION IV OVERVIEW

Section IV Publication Release Modifications provides a listing of the approved additions, deletions, and changes made to the values since the last publication release of the External Code List document.

D. REQUESTS FOR MODIFICATIONS

1. NCPDP Data Elements

Request for additions, deletions, and changes to the values of an NCPDP data element (Section II and Section III, Subsection A) should be submitted on a Data Element Request Form (DERF). The process for submitting, reviewing, approving and implementing these requests is described in the ECL Process Overview document. For a copy of the most current DERF form please contact the Council office or go to www.ncpdp.org. Refer to the DERF for instructions on completing and submitting the form.

2. ASC X12N Data Elements

Section III, subsection B lists the ASC X12 code values that were incorporated into the NCPDP SCRIPT Standard for common usage and harmonization of values in the healthcare industry. The code values are under the purview of ASC X12 and the code set maintainers. During the creation of NCPDP SCRIPT Standard, values thought useful were brought forward for these data elements.

If new code values are desired, they should be requested via the X12 process of Data Maintenance (DM). Upon X12 approval, a DERF should be submitted for inclusion into this document. ASC X12 Data Maintenance information can be found at http://www.x12.org/ click on "Online DM Submission".

3. UN/EDIFACT Data Elements

Section III, subsection C lists the UN/EDIFACT code values that were incorporated into the NCPDP SCRIPT Standard for common usage and harmonization of values in the healthcare industry. The code values are

under the purview of UN /EDIFACT and the code set maintainers. During the creation of NCPDP SCRIPT Standard, values thought useful were brought forward for these data elements.

If new code values are desired, they should be requested via the X12 process of Data Maintenance (DM). Upon X12 approval, a DERF should be submitted for inclusion into this document. ASC X12 Data Maintenance information can be found at http://www.x12.org/ click on "Online DM Submission".

E. NCPDP REVIEW OF MODIFICATION REQUESTS

The NCPDP Work Groups and MC Maintenance and Control meet quarterly at the Joint Technical Work Group Meetings and DERF requests are reviewed at that time. Approved requests as a result of the Work Groups and MC Maintenance and Control review will be published quarterly.

F. STANDARDS FORMAT KEY

STANDARD FORMATS KEY (THROUGHOUT DOCUMENT)

A = Post Adjudication
B = Batch Standard
C = Claims Billing Tape Format
D = Diskette Billing Format
F = Formulary and Benefit Standard
G = Medicaid Subrogation
H = Health Care ID Card
M = Member Enrollment Standard
N = Financial Information Reporting
P = Claim Payment Tape Format
R = Manufacturer Rebates Standard
S = SCRIPT Standard
T = Telecommunication Standard
U = Billing Unit Standard
V = Prescription Transfer Standard

G. PUBLICATION RELEASE DATE OF THE ECL AND USE

The publication release date of the External Code List (ECL) occurs whenever values are added, changed, or deleted. Use of the values associated with each data element is by the release date of the External Code List document as a whole and not by the individual data element. A payer, pharmacist, prescriber, or manufacturer is required to support all the values listed within a release of an External Code List for all the data elements used within their transactions. This method supports the publishing of all External Code Lists governed under a given release date.

For example,
If in External Code List dated March 2ØØ5, the following data elements were updated with new Values:

- Approved Message Code
- Delay Reason Code
- Coupon Type

An entity has a business need to support the new values for Approved Message Code, but not the new values for Delay Reason Code or Coupon Type. Should the entity use the new values for Approved Message Code, the new values added to Delay Reason Code and Coupon Type should not be rejected as invalid codes, according to the standard that is being supported. The new value(s) should be ignored. It is expected that the Payer Templates/Sheets/Provider Manuals indicate which External Code List release date is supported.

NCPDP Standards Version Usage for the ECL		
Standard	**Version**	**ECL Publication Date**
Manufacturer Rebates	Ø3.Ø2 and greater	November 2ØØ3 and above
Telecommunication	9.Ø and greater	May 2ØØ4 and above
SCRIPT	5.Ø and greater	May 2ØØ4 and above
Formulary and Benefit	1.Ø and greater	October 2ØØ5 and above
Medicaid Subrogation	3.Ø and greater	July 2ØØ7 and above
Post Adjudication	1.Ø and greater	September 2ØØ6 and above
Financial Information Reporting	1.Ø and greater	January 2ØØ8 and above
Prescription Transfer	1.Ø and greater	January 2ØØ8 and above

Please refer to the Standards Matrix document on the NCPDP website, ncpdp.org, regarding lower versions of standards shown above. The ECL was not in affect for these lower versions and the NCPDP Data Dictionary must be used.

Any questions regarding the content or the intent of the information presented herein should be addressed to the Council office:

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II. NCPDP VALUES LISTED BY DATA ELEMENT

655-S6 – Accumulator Month

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the accumulator month based on date of service of claims activity.	9(2)	N	

Values:

CODE	DESCRIPTION
1	January
2	February
3	March
4	April
5	May
6	June
7	July
8	August
9	September
1Ø	October
11	November
12	December

369-2Q - Additional Documentation Type ID

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Unique identifier for the data being submitted.	x(3)	T	Used in Telecommunication Standard Version C.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
ØØ1	Medicare = Ø1.Ø2A Hospital Beds
ØØ2	Medicare = Ø1.Ø2B Support Surfaces
ØØ3	Medicare = Ø2.Ø3A Motorized Wheel Chair
ØØ4	Medicare = Ø2.Ø3B Manual Wheelchair
ØØ5	Medicare = Ø3.Ø2 Continuous Positive Airway Pressure (CPAP)
ØØ6	Medicare = Ø4.Ø3B Lymphedema Pumps
ØØ7	Medicare = Ø4.Ø3C Osteogenesis Stimulator
ØØ8	Medicare = Ø6.Ø2B Transcutaneous Electrical Nerve Stimulator TENS)
ØØ9	Medicare = Ø7.Ø2A Seat Lift Mechanisms
Ø1Ø	Medicare = Ø7.Ø2B Power Operated Vehicles (POV)
Ø11	Medicare = Ø8.Ø2 Immunosuppressive Drugs
Ø12	Medicare = Ø9.Ø2 Infusion Pump
Ø13	Medicare = 1Ø.Ø2A Parenteral Nutrition
Ø14	Medicare = 1Ø.Ø2B Enteral Nutrition
Ø15	Medicare = 484.2 Oxygen

131-UG – Additional Message Information Continuity

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates continuity of the text found in the current repetition of 'Additional Message Information' (526-FQ) with the text found in the next repetition that follows.	X(1)	T	Used in Telecommunication Standard Version D.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
+	Current text continues

132-UH – Additional Message Information Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	T	Used in Telecommunication Standard Version D.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
Ø1	Used for first line of free form text with no pre-defined structure.
Ø2	Used for second line of free form text with no pre-defined structure.
Ø3	Used for third line of free form text with no pre-defined structure.
Ø4	Used for fourth line of free form text with no pre-defined structure.
Ø5	Used for fifth line of free form text with no pre-defined structure.
Ø6	Used for sixth line of free form text with no pre-defined structure.
Ø7	Used for seventh line of free form text with no pre-defined structure.
Ø8	Used for eighth line of free form text with no pre-defined structure.
Ø9	Used for ninth line of free form text with no pre-defined structure.

6Ø4-NA – Address Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier of the address.	9(2)	V	

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Primary - The place of permanent residence. This is the first address of choice for mailing prescriptions and invoices.
2	Shipping - Where the item must be mailed to if other than the primary address
3	Billing - Where the invoice associated with the item must be mailed to unless the invoice accompanies the actual shipment
4	Alternate - An alternative to Primary Address
5	Long-term Care Facility Address - The facility address for LTC facility resident

6ØØ-58 - Adjudicator ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of code being submitted in the 'Adjudicator ID Code' (6ØØ-57) field.	x(1)	R	

Values:

CODE	DESCRIPTION
C	Contracting Organization (PMO) assigned ID number – Alphanumeric code used to identify the PMO that sent a NCPDP manufacturer rebate flat file standard layout to a PICO. This code is an internal number assigned by the PMO.
D	DEA Number – The number assigned by the DEA to all businesses that manufacturer or distribute controlled pharmaceuticals, all health professionals who dispense, administer, or prescribe controlled pharmaceuticals and all pharmacies that fill prescriptions.
F	Federal Tax ID Number – A 9-digit number assigned by the Internal Revenue Service to sole proprietors, corporations, partnerships, estates, trusts, and other entities for the purpose of tax filing and reporting.
H	HIBCC 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.
M	Manufacturer (PICO) assigned ID Number-A value assigned by a manufacturer and used internally to identify a given trading partner.
P	National Provider ID (NPI) –A HIPAA-mandated standard unique health identifier for health care providers
T	Telephone number – Code indicating that the information to follow is a telephone number (for voice, data, fax, etc.).
Z	Mutually agreed upon number- A value mutually agreed upon by trading partners to identify a given data element. The value may be unique between the trading partners or from an existing industry standard.

2Ø5 - Adjustment Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Type of adjustment.	X(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Debit – An adjustment resulting in an increased payment amount.
2	Credit– An adjustment resulting in a decreased payment amount.

2Ø7 - Administrative Fee Effect Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates how the transaction should be counted for administrative fee determination.	X(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
A	Add to count
S	Subtracts from count

576-MQ - Amount Attributed To Product Selection Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Amount Attributed To Product Selection' (519-FJ).	X(2)	T	Used only in Telecommunication Standard Version C.3 and C.4. Field was deleted in Telecommunication Standard Version D.Ø.

Values:

CODE	DESCRIPTION
Ø1	Brand Selection
Ø2	Non-preferred Formulary Selection
Ø3	Brand Non-Preferred Formulary Selection

548-6F - Approved Message Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Message code, on an approved claim/service, communicating the need for an additional follow-up.	x(3)	T	

Values:

CODE	DESCRIPTION
Blank	Not Specified
ØØ1	Generic Available-Message from Processor to the pharmacist that a generic equivalent product is available when a claim is submitted for a brand-name product.
ØØ2	Non-Formulary Drug- Response code indicating that the prescribed drug is not included in the plan formulary.
ØØ3	Maintenance Drug –Medication used to control the symptoms of a chronic condition.
ØØ4	Filled During Transition Benefit - The drug was paid because the Medicare Part D patient is in a transitional drug benefit period.
ØØ5	Filled During Transition Benefit/Prior Authorization Required - The drug was paid because the Medicare Part D patient is in a transitional drug benefit period but would have rejected due to the need for a prior authorization
ØØ6	Filled During Transition Benefit/Non-Formulary - The drug was paid because the Medicare Part D patient is in a transitional drug benefit period. After the transition drug benefit period, this drug would be considered non-formulary and not payable.
ØØ7	Filled During Transition Benefit/Other Rejection - The drug was paid because the Medicare Part D patient is in a transitional drug benefit period. After the transition drug benefit period, this drug will reject for plan limitations or other reason(s).
ØØ8	Emergency Fill Situation - This drug was paid because it is a first time fill for a Medicare Part D patient who is not within a transitional drug benefit period.
ØØ9	Emergency Fill Situation/Prior Authorization Required -This drug was paid because it is a first time fill for a Medicare Part D patient who is not within a transitional drug benefit period but would have rejected due to the need for a prior authorization.
Ø1Ø	Emergency Fill Situation/Non-Formulary - This drug was paid because it is a first time fill for

CODE	DESCRIPTION
	a Medicare Part D patient who is not within a transitional drug benefit period but would have rejected as non-formulary or not covered.
Ø11	Emergency Fill Situation/Other Rejection - This drug was paid because it is a first time fill for a Medicare Part D patient who is not within a transitional drug benefit period but would have rejected for plan limitations or other reason(s).
Ø12	Level of Care Change - This drug was paid because the patient has had a change in level of care
Ø13	Level Of Care Change/Prior Authorization Required - This drug was paid because it was determined that the patient has had a change in level of care. Future fills of this drug under the same level of care will reject unless a prior auth is submitted and approved by the plan.
Ø14	Level Of Care Change/Non-Formulary This drug was paid because it was determined that the patient has had a change in level of care. Future fills of this drug under the same level of care will reject because of plan limitations of other reason(s).
Ø15	Level of Care Change/Other Rejection - This drug was paid because it was determined that the patient has had a change in level of care. Future fills of this drug under the same level of care will reject as non-formulary or not covered.

598-PJ - Authorized Representative State/Province Address

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Standard State/Province code as defined by appropriate government agency.	x(2)	T	

Values:

CODE	DESCRIPTION
See Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

6Ø1-76 - Base Price Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The type of base price on which the rebate amount is based.	x(3)	R	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Field was deleted in Manufacturer Rebates Standard Version Ø4.Ø1

Values:

CODE	DESCRIPTION
AMP	Average Manufacturer Price
ASP	Average Sales Price= The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs.
AWP	Average Wholesale Price
BP	Best Price
CON	Contracted
DIR	Direct
EAC	Estimated Acquisition Cost
LST	List
NDP	National Distributor Pricing
NOM	Nominal

CODE	DESCRIPTION
NWP	National Wholesaler Price
WAC	Wholesale Acquisition Cost
Z__	Mutually agreed upon Base Price Type (All codes beginning with the letter Z are reserved for use between trading partners.)

6Ø1-79 - Baseline Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The type of baseline on which the rebate amount is based.	x(3)	R	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Field was deleted in Manufacturer Rebates Standard Version Ø4.Ø1

Values:

CODE	DESCRIPTION
LM	Last Month
LY	Last Year
MBR	Membership
NAT	National
ORG	Organizational
PMM	PMPM Baseline-(Per Member Per Month)
PMQ	PMPQ Baseline-(Per Member Per Quarter)
PMY	PMPY Baseline-(Per Member Per Year)
PUR	Purchase
RQ	Rolling Quarter
UTL	Utilization
Z__	Mutually Agreed Upon Baseline Quantifiers (All codes beginning with the letter Z are reserved for use between trading partners.)

573-4V - Basis Of Calculation - Coinsurance

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating how the Coinsurance reimbursement amount was calculated for 'Patient Pay Amount' (5Ø5-F5).	x(2)	T,A	Used in Telecommunication Standard Version C.2 or greater but not in lower versions.

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions C.2 through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
ØØ	Not Specified	Used only in Telecommunication Standard Versions C.2 through C.4 and Post Adjudication Standard

		Version 1.Ø. Value was deleted and cannot be used in higher versions.
Ø1	Quantity Dispensed - *The quantity of the prescription dispensed for the patient.*	
Ø2	Quantity Intended To Be Dispensed - Indicates that the originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order.	
Ø3	Usual and Customary/Prorated - Used when payment is based upon the submitted U&C value rather than the calculated/contracted rate, causing a situation where the copay/dispensing fee is higher than the U&C value, so the plan/processor returns a copay/dispensing fee to the provider which is less than the plan copay/dispensing fee, thereby being prorated.	
Ø4	Waived Due To Partial Fill – Due to the fact that the provider is submitting a partial fill transaction (no assumptions are being made as to whether this is the initial billing or the final billing in a partial fill situation), the plan/processor may elect not to apply a copay or a dispensing fee on one or both of those partial fill transactions.	
99	Other - Different from those implied or specified.	

347-HJ - Basis Of Calculation - Copay

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating how the Copay reimbursement amount was calculated for 'Patient Pay Amount' (5Ø5-F5).	x(2)	T,A	Used in Telecommunication Standard Version C.2 or greater but not in lower versions.

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions C.2 through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
ØØ	Not Specified	Used only in Telecommunication Standard Versions C.2 through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
Ø1	Quantity Dispensed - The quantity of the prescription dispensed for the patient.	
Ø2	Quantity Intended To Be Dispensed - Indicates that the originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order.	
Ø3	Usual and Customary/Prorated - Used when payment is based upon the submitted U&C value rather than the calculated/contracted rate, causing a situation where the copay/dispensing fee is higher than the U&C value, so the plan/processor returns a copay/dispensing fee to the provider which is less than the plan copay/dispensing fee, thereby	

CODE	DESCRIPTION	Value Limitations
	being prorated.	
Ø4	Waived Due To Partial Fill – Due to the fact that the provider is submitting a partial fill transaction (no assumptions are being made as to whether this is the initial billing or the final billing in a partial fill situation), the plan/processor may elect not to apply a copay or a dispensing fee on one or both of those partial fill transactions.	
99	Other - Different from those implied or specified.	

346-HH - Basis Of Calculation - Dispensing Fee

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating how the reimbursement amount was calculated for 'Dispensing Fee Paid' (5Ø7-F7).	x(2)	T,A	

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified (This value is not allowed for the Telecommunication Standard Versions D.Ø and greater)	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
ØØ	Not Specified (This value is not allowed for the Telecommunication Standard Versions D.Ø and greater)	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
Ø1	Quantity Dispensed - The quantity of the prescription dispensed for the patient.	
Ø2	Quantity Intended To Be Dispensed - Indicates that the originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order.	
Ø3	Usual and Customary/Prorated - Used when payment is based upon the submitted U&C value rather than the calculated/contracted rate, causing a situation where the copay/dispensing fee is higher than the U&C value, so the plan/processor returns a copay/dispensing fee to the provider which is less than the plan copay/dispensing fee, thereby being prorated.	
Ø4	Waived Due To Partial Fill – Due to the fact that the provider is submitting a partial fill transaction (no assumptions are being made as to whether this is the initial billing or the final billing in a partial fill situation), the plan/processor may elect not to apply a copay or a dispensing fee on one or both of those partial fill transactions.	
99	Other - Different from those implied or specified.	

348-HK - Basis Of Calculation - Flat Sales Tax

Definition of Field	Field Format	Standard/Version Formats	Field Limitations

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating how the reimbursement amount was calculated for 'Flat Sales Tax Amount Paid' (558-AW).	x(2)	T,A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
ØØ	Not Specified
Ø1	Quantity Dispensed - The quantity of the prescription dispensed for the patient.
Ø2	Quantity Intended To Be Dispensed - Indicates that the originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order.

349-HM - Basis Of Calculation - Percentage Sales Tax

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating how the reimbursement amount was calculated for 'Percentage Sales Tax Amount Paid' (559-AX).	x(2)	T,A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
ØØ	Not Specified
Ø1	Quantity Dispensed - The quantity of the prescription dispensed for the patient.
Ø2	Quantity Intended To Be Dispensed - Indicates that the originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order.

423-DN - Basis Of Cost Determination

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the method by which 'Ingredient Cost Submitted' (Field 4Ø9-D9) was calculated.	x(2)	T,C	

Values:

CODE	DESCRIPTION
See Section II, APPENDIX I – VALUES FOR BASIS OF COST DETERMINATION CODES	

522-FM - Basis Of Reimbursement Determination

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	9(2)	T,P,A	

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Ingredient Cost Paid as Submitted -Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item.
2	Ingredient Cost Reduced to AWP Pricing -Used to indicate when reimbursement is based upon the average wholesale price for the prescription item.
3	Ingredient Cost Reduced to AWP Less X% Pricing - Used to indicate when reimbursement is based on a discounted average wholesale price for the prescription item.
4	Usual & Customary Paid as Submitted – Indicates when the ingredient cost reimbursed to the provider is based upon the submitted Usual and Customary Price.
5	Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary – Used to indicate that the processor has compared submitted U&C to the cost plus the fee (May be either their negotiated value for cost plus fee, or the submitted cost and fee), and is paying the lower of the amounts.
6	MAC Pricing Ingredient Cost Paid - Indicates when the ingredient cost reimbursed to the provider is based upon a payer's Maximum Allowable Cost list. (when MAC Basis of Cost was submitted)
7	MAC Pricing Ingredient Cost Reduced to MAC - Indicates when the ingredient cost reimbursed to the provider is based upon a payer's Maximum Allowable Cost list. (when other than MAC Basis of Cost was submitted)
8	Contract Pricing – Price based upon contractual agreement between trading partners.
9	Acquisition Pricing - Used to indicate when reimbursement is based upon the actual cost of the item.
1Ø	ASP (Average Sales Price) -The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs.
11	AMP (Average Manufacturer Price) - The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer.
12	34ØB/Disproportionate Share/Public Health Service Pricing - The 34ØB Drug Pricing Program from the Public Health Service Act, sometimes referred to as "PHS Pricing" or "6Ø2 Pricing" is a federal program that requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics, and hospitals (termed "covered entities") at a reduced price.
13	WAC (Wholesale Acquisition Cost) – A cost as defined in Title XIX, Section 1927 of the Social Security Act.
14	Other Payer-Patient Responsibility Amount - Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).
15	Patient Pay Amount - Indicates reimbursement was based on the Patient Pay Amount (5Ø5-F5).
16	Coupon Payment – Indicates reimbursement was based on the Coupon Value Amount (487-NE) submitted or coupon amount determined by the processor.

498-PD - Basis Of Request

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code describing the reason for prior authorization request.	x(2)	T	

Values:

CODE	DESCRIPTION
ME	Medical Exception –A medical case that does not conform to normal rules.
PR	Plan Requirement – Code indicating that the Prior Authorization Segment is being submitted because the payer/plan requires prior authorization as a condition of coverage.

PL	Increase Plan Limitation-To allow dispensing above the restrictions imposed by the plan.

393-MV - Benefit Stage Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Benefit Stage Amount' (394-MW).	x(2)	T,R,A	Used in Telecommunication Standard Version C.3 or greater but not in lower versions. Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions. Used in Post Adjudication Standard Version 2.Ø but not in lower version.

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions C.3 and C.4. Value was deleted for use in higher versions of this standard.
Ø1	Deductible - The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.	
Ø2	Initial Benefit - The first monthly benefit, or the first monthly benefit following any break in participation.	
Ø3	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.	
Ø4	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.	

212 - Benefit Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the type of acceptable claims for the group based on the Benefit setup.	X(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Mail Order Only - Claims accepted for payment only when dispensed by pharmacies that primarily conduct their business by delivering the filled prescriptions by mail or parcel service.
2	Mail Order Member Paper Only – Claims accepted for payment only when dispensed by pharmacies that primarily conduct their business by delivering the filled prescriptions by mail or parcel service and only when the claim is submitted by the member via a request for reimbursement.
3	Card Only - Claims accepted for payment only when the prescription is dispensed at retail pharmacies.

CODE	DESCRIPTION
4	Member Paper Only – Claims accepted for payment when the claim is submitted by the member requesting reimbursement.
5	Standard Program (Integrated Card, Mail Service & Member Paper Programs) – Claims accepted from all types of dispensing providers and paper claims submitted requesting reimbursement after dispensing.
6	Card and member paper only - Claims accepted for payment only when the prescription is dispensed at a retail pharmacy, or when a paper claim is submitted by the member requesting reimbursement
7	Mail and Card Only - Claims accepted for payment only when dispensed by mail service or retail pharmacies; claims submitted by the member requesting reimbursement are not covered.
8	Discount Card Program – Claims accepted but members are required to pay 100% copay for all types of pharmacy claims.

117-TR - Billing Entity Type Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
A code that identifies the entity submitting the billing transaction.	9(2)	T	Used in Telecommunication Standard Version D.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
ØØ	Provider Submitted-Pay to Provider
Ø1	Provider Submitted-Pay to Another Party
Ø2	Agent Submitted-Pay to Agent
Ø3	Agent Submitted-Pay to Another Party

6ØØ-6Ø - Branded Generic Co-pay Confidential

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates whether or not the branded generic co-pay is confidential; does not imply that the branded or generic product co-pay amount fields are reported.	x(1)	R	

Values:

CODE	DESCRIPTION
N	No
Y	Yes

81Ø-1G - Carrier Location State

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
State of the carrier.	x(2)	P	

Values:

CODE	DESCRIPTION
See Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

6ØØ-64 – Change Identifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies type of change being made.	x(1)	R, F	

Values: For R

CODE	DESCRIPTION
A	Addition - Code indicating something added
C	Change - Code indicating something altered
D	Delete - Code indicating something to be cancelled
R	Replace - To provide a substitute

Values: For F

CODE	DESCRIPTION
A	Addition- Code indicating something added
C	Change - Code indicating something altered
D	Delete - Code indicating something to be cancelled

218 – Claim Media Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Claim submission type code.	X(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	POS Claim –A Point-Of-Sale transaction submitted in a real-time mode.
2	Batch Claim – A non real-time transaction submitted when an immediate response is not available or required.
3	Pharmacy Submitted Paper Claim (UCF) – A non-electronic transaction submitted via an NCPDP-developed Universal Claim Form.
4	Member Submitted Paper Claim (Direct Member Reimbursement (DMR)) – A claim submitted by the member requesting reimbursement.
5	Other - Different from the codes already specified

221 – Client Formulary Flag

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates that client has a formulary.	X(1)	A	

Values:

CODE	DESCRIPTION

Blank	Not Specified
Y	Yes
N	No

223 – Client Pricing Basis Of Cost

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	x(2)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø1	Average Wholesale Price - The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed.
Ø2	Acquisition Cost (ACQ) – Price based on the acquisition cost for the package size dispensed.
Ø3	Manufacturer Direct Price– Price the submitter paid for the drug purchased directly from the manufacturer.
Ø4	Federal Upper Limit (FUL) –The maximum allowable cost that federal programs will reimburse.
Ø5	Average Generic Price – An average price of generics in the same chemical strength and dosage form of the dispensed medication.
Ø6	Usual & Customary - The pharmacy's price for the medication for a person paying cash on the day of dispensing.
Ø7	Submitted Ingredient Cost - Ingredient cost submitted by the pharmacy on the claim
Ø8	State MAC– The maximum allowable unit cost as published by the State Medicaid Agency.
Ø9	Unit - The price per unit of the drug.
1Ø	Usual & Customary or Copay – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.

528-FS – Clinical Significance Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the significance or severity level of a clinical event as contained in the originating database.	x(1)	T	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Major - Code indicating that an event, transaction, etc. is of the highest importance; action required to prevent adverse drug event.
2	Moderate – Code indicating that an event, transaction, etc. is of mid-level significance; requires thoughtful review before prescribing/dispensing the medication. Risk vs. benefit should be evaluated.
3	Minor – Code indicating a non-life threatening, annoying, or now-well-documented effect which may or may not require a change in drug therapy.
9	Undetermined - value to describe a professional service with variable or unknown severity.

997-G2 - CMS Part D Defined Qualified Facility

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates that the patient resides in a facility that qualifies for the CMS Part D benefit.	X(1)	T,A	Used in Telecommunication Standard Version C.4 or greater but not in lower versions. Used in Post Adjudication Standard Version 2.Ø but not in lower version.

Values:

CODE	DESCRIPTION
Y	Yes=CMS qualified facility
N	No=Not a CMS qualified facility

226 – COB Primary Claim Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
For secondary coordination of benefits claims. Indicates the claim type of the primary claim.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Secondary Claims Not Processed – Supplemental claims are not eligible for COB.
J	Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB
M	Mail Service - Pharmaceutical claims dispensed out of a Mail Order Facility.
R	Retail - Pharmaceutical claims dispensed out of a Retail pharmacy.

239 – Communication Type Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
For Mail Service Claims Only - Identifies the type of communication used by either prescriber or patient to initiate the request for the fill.	X(2)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
E	Email (Electronic mail) -The exchange of electronic messages and computer files between computers that are connected to the Internet or some other computer network.
F	Fax - Prescription obtained via transmission using a fax machine.
I	Interactive Voice Response Unit (IVRU) - a phone technology that allows a computer to detect voice and touch tones using a normal phone call. The IVRU system can respond with pre-recorded or dynamically generated audio to further direct callers on how to proceed. IVRU systems can be used to control almost any function where the interface can be broken down into a series of simple menu choices.
D	Directly delivered to pharmacy (delivery service/mail/walk in) -delivered to the pharmacy personally

CODE	DESCRIPTION
P	Electronic Prescription – a computer based means of transmitting a prescription
V	Customer Service (phoned in) – Use of a telephone to communicate information
W	Website - A site (location) on the World Wide Web. Each website contains a homepage, which is the first document users see when they enter the site. The site might also contain additional documents and files. Each site is owned and managed by an individual, company, or organization

4Ø6-D6 - Compound Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating whether or not the prescription is a compound.	9(1)	C, D, P, T,A,R,V	

Values:

CODE	DESCRIPTION
Ø	Not Specified (This value is not allowed for the Telecommunication Standard)
1	Not a Compound—Medication that is available commercially as a dispensable product
2	Compound – Customized medication prepared in a pharmacy by combining, mixing, or altering of ingredients (but not reconstituting) for an individual patient in response to a licensed practitioner's prescription

451-EG – Compound Dispensing Unit Form Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
NCPDP standard product billing codes.	9(1)	T	

Values:

CODE	DESCRIPTION
1	Each - Being one or individual.
2	Grams - A metric unit of mass equal to one thousandth of a kilogram.
3	Milliliters - A metric measure of volume equal to one thousandth of a liter.

45Ø-EF - Compound Dosage Form Description Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Dosage form of the complete compound mixture.	x(2)	T	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø1	Capsule—a soluble dispensable unit enclosing a single dose of a medication or combination of medications
Ø2	Ointment—a semisolid preparation, used as a vehicle for medication and applied externally to the body

CODE	DESCRIPTION
Ø3	Cream--a soft solid or thick liquid containing medication, applied externally for a prophylactic, therapeutic, or cosmetic purpose.
Ø4	Suppository—a dispensable unit containing a single dose of medication or combination of medications to be introduced into a body orifice, such as the rectum, urethra, or vagina
Ø5	Powder—finely ground particles of a solid medication
Ø6	Emulsion—a mixture of two immiscible liquids, one being dispersed throughout the other in small droplets
Ø7	Liquid—a substance that flows readily in its natural state
1Ø	Tablet—a single dispensable unit containing one or more medications, with or without a suitable diluent
11	Solution—a homogeneous mixture of one or more liquids
12	Suspension—a preparation of a powdered form of a drug incorporated into a suitable liquid vehicle
13	Lotion—a liquid suspension for external application to the body
14	Shampoo—a liquid preparation (solution, suspension, emulsion) for external application to the scalp
15	Elixir—a clear, sweetened, usually hydroalcoholic liquid containing flavoring substance and one or more medications
16	Syrup—a concentrated solution of a sugar in water or other aqueous liquid and one or more medications
17	Lozenge—a solid, single dispensable unit containing one or more medications intended for dissolution in the mouth
18	Enema—a liquid preparation intended for introduction into the rectum containing one or more medications

49Ø-UE - Compound Ingredient Basis of Cost Determination

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.	x(2)	T,A	

Values:

CODE	DESCRIPTION
See Section II, APPENDIX I – VALUES FOR BASIS OF COST DETERMINATION CODES	

488-RE - Compound Product ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the type of product dispensed.	x(2)	T,A	

Values:

CODE	DESCRIPTION
See Section II, Appendix B1 – Product/Service Qualifier	

452-EH - Compound Route of Administration

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code for the route of administration of the complete compound mixture.	9(2)	T,A	Used in Telecommunication Standard Version 9.Ø through C.3 and Post Adjudication Standard Version 1.Ø. Field was replaced in Telecommunication Standard Version C.4 and Post Adjudication Standard Version 2.Ø with *Route of Administration 995-E2*

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Buccal
2	Dental
3	Inhalation
4	Injection
5	Intraperitoneal
6	Irrigation
7	Mouth/Throat
8	Mucous Membrane
9	Nasal
1Ø	Ophthalmic
11	Oral
12	Other/Miscellaneous
13	Otic
14	Perfusion
15	Rectal
16	Sublingual
17	Topical
18	Transdermal
19	Translingual
2Ø	Urethral
21	Vaginal
22	Enteral

996-G1 - Compound Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Clarifies the type of compound.	X(2)	T,A	Used in Telecommunication Standard Version C.4 or greater but not in lower versions. Used in Post Adjudication Standard Version 2.Ø but not in lower version.

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used in Telecommunication Standard Version C.4 only. Value was deleted for use in higher versions of this standard.
Ø1	Anti-infective—a medicinal product intended to treat pathogens such as bacteria, viruses, fungi or parasites	

CODE	DESCRIPTION	Value Limitations
Ø2	Ionotropic—a medicinal product intended to correct irregular heart rhythms	
Ø3	Chemotherapy—a medicinal product intended to treat cancer	
Ø4	Pain management—a regimen of therapy intended to ameliorate mild to severe discomfort	
Ø5	TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition—products intended to provide nourishment by central or peripheral veins for patients with compromised digestive tracts	
Ø6	Hydration—a product intended to restore body fluids	
Ø7	Ophthalmic—a product intended to be applied to or instill in the surface of the eye	
99	Other—not defined by other available codes	

6ØØ-71 - Contracting Organization (PMO) ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the type of data being submitted in the 'Contracting Organization (PMO) ID Code' (6ØØ-66) field.	x(2)	R	Used in Manufacturer Rebates Standard Version Ø4.Ø1 or greater but not in lower versions. For Manufacturer Rebates Standard Version Ø3.Ø2 only the old field name of FF Contracting Organization (PMO) ID Qualifier must be used.

Values:

CODE	DESCRIPTION
C	Contracting organization (PMO) assigned ID number - Alphanumeric code used to identify the PMO that sent a NCPDP manufacturer rebate flat file standard layout to a PICO. This code is an internal number assigned by the PMO.
D	DEA number - The number assigned by the DEA to all businesses that manufacturer or distribute controlled pharmaceuticals, all health professionals who dispense, administer, or prescribe controlled pharmaceuticals an all pharmacies that fill prescriptions.
F	Federal Tax ID number –– A 9-digit number assigned by the Internal Revenue Service to sole proprietors, corporations, partnerships, estates, trusts, and other entities for the purpose of tax filing and reporting.
H	HIBCC 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.
M	Manufacturer (PICO) assigned ID number- A value assigned by a manufacturer and used internally to identify a given trading partner.
P	National Provider ID (NPI) –A HIPAA-mandated standard unique health identifier for health care providers
T	Telephone number - Code indicating that the information to follow is a telephone number (for voice, data, fax, etc.).
Z	Mutually agreed upon ID number- A value mutually agreed upon by trading partners to identify a given data element. The value may be unique between the trading partners or from an existing industry standard.

9Ø8-BW - Copay List Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the type of copay being conveyed.	x(2)	F	

Values:

CODE	DESCRIPTION
SL	Summary Level – Indicates that the detail listed is summarized according to the criteria specified within the detailed records (e.g. formulary status, product type, pharmacy type, etc.) vs. for specific drugs.
DS	Drug Specific – Used to identify those copay values which are unique to a certain drug or drug group.

485-KE - Coupon Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the type of coupon being used.	x(2)	T	

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in higher versions.
Ø1	Price Discount – a reduced cost for the product incurred by the bearer of the coupon.	
Ø2	Free Product – no cost incurred for the product by the bearer of the coupon.	
99	Other - Different from those implied or specified	

912-B3 - Coverage List Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the type of coverage rule being conveyed.	x(2)	F	

Values:

CODE	DESCRIPTION
AL	Age Limits – Age restrictions placed on medications by formularies to limit use to certain populations based on cost and availability of appropriate alternative therapies.
DE	Product Coverage Exclusion – Used to indicate the list of products provided is excluded from being paid by the plan rules.
GL	Gender Limits-Indicator used in the Formulary and Benefits Standard to convey that gender constraints apply to the coverage of the specified product, i.e., the product is allowed only for males or only for females.
MN	Medical Necessity- Indicator used to convey that medically necessary constraints apply to the coverage of the specified product, i.e. criteria requiring or excluding specific related diagnoses, failed treatment attempts, functional limitations, etc.
PA	Prior Authorization – a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependant upon the prescriber submitting

CODE	DESCRIPTION
	the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product.
QL	Quantity Limits – Indicator used to convey that quantity constraints apply to the coverage of the specified product, e.g. the maximum allowed quantity of Viagra is 3 tablets per month.
RD	Resource Link – Drug-Specific Level – Indicates that the resource link is for the specified drug and coverage type listed in the record.
RS	Resource Link – Summary Level – Indicates that the resource link is for all the drugs within the coverage type listed in the record.
SM	Step Medications – Indicates that this coverage list defines step therapy medication and lists the detailed step medications within the therapy.
ST	Step Therapy – Indicates that this coverage list defines step therapy medications—but does not list the step medications.
TM	Coverage Text Message – A code indicating a free form description of the type of coverage

532-FW - Database Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the source of drug information used for DUR processing.	x(1)	T,A	

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions C.2 through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
1	First DataBank – a drug database company	
2	Medi-Span Product Line – a drug database company	
3	Micromedex/Medical Economics– a drug database company	
4	Processor Developed – a proprietary drug file	
5	Other - Different from those implied or specified	
6	Redbook – a Micromedex publication of drug information	
7	Multum– a drug database company	

6Ø1-31 – Data Level

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The level of data being submitted.	x(2)	R	

Values:

CODE	DESCRIPTION	Value Limitation
CI	Contracting organization pharmacy ID level	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Value was deleted and cannot be used in higher versions.

CODE	DESCRIPTION	Value Limitation
CN	Contracting organization NDC level - The level of data being submitted by a PMO for manufacturer rebates summarized across fill dates at the NDC level.	
CP	Contracting organization prescription level - The level of data being submitted by a PMO for manufacturer rebates at the RX detail level.	
CZ	Contracting organization pharmacy zip code level	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Value was deleted and cannot be used in higher versions.
PI	Plan pharmacy ID level	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Value was deleted and cannot be used in higher versions.
PN	Plan NDC level - Product utilization is submitted for rebate consideration by summarizing each Plan and NDC that had adjudicated claims that reporting period.	
PP	Plan prescription level - Product utilization is submitted for rebate consideration by each Plan at a prescription level.	
PZ	Plan pharmacy zip code level	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Value was deleted and cannot be used in higher versions.
ZZ	Mutually agreed upon level - The mutually agreed data level to be exchanged between trading partners (i.e. summary of PN level vs. detail or PP level data records) for manufacturer rebates.	

6Ø1-37 - Data Provider ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of data being submitted in the 'Data Provider ID Code' (6Ø1-32) field.	x(2)	R	Used in Manufacturer Rebates Standard Version Ø4.Ø1 or greater but not in lower versions. For Manufacturer Rebates Standard Version Ø3.Ø2 only the old field name of FF Contracting Organization (PMO) ID Qualifier must be used.

Values:

CODE	DESCRIPTION
C	Contracting organization (PMO) assigned ID number - Alphanumeric code used to identify the PMO that sent a NCPDP manufacturer rebate flat file standard layout to a PICO. This code is an internal number assigned by the PMO.
D	DEA number - The number assigned by the DEA to all businesses that manufacturer or distribute controlled pharmaceuticals, all health professionals who dispense, administer, or prescribe controlled pharmaceuticals an all pharmacies that fill prescriptions.
F	Federal Tax ID number - A 9-digit number assigned by the Internal Revenue Service to sole proprietors, corporations, partnerships, estates, trusts, and other entities for the purpose of tax filing and reporting.
H	HIBCC HIN -- A 9 digit alphanumeric number used to identify health care entities such as

CODE	DESCRIPTION
	veterinarians, animal clinics, and health care provider facilities. The number is assigned by HIBCC.
M	Manufacturer (PICO) assigned ID number- A value assigned by a manufacturer and used internally to identify a given trading partner.
P	National Provider ID (NPI) –A HIPAA-mandated standard unique health identifier for health care providers
T	Telephone number - Code indicating that the information to follow is a telephone number (for voice, data, fax, etc.).
Z	Mutually agreed upon ID number- A value mutually agreed upon by trading partners to identify a given data element. The value may be unique between the trading partners or from an existing industry standard.

357-NV - Delay Reason Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code to specify the reason that submission of the transactions has been delayed.	9(2)	T	

Values:

CODE	DESCRIPTION
1	Proof of eligibility unknown or unavailable - Transaction delayed because identification card or verification transaction not available, or patient enrollment in benefit plan not complete at the time of service.
2	Litigation - Transaction delayed because litigation to determine liability for medical expenditures was unresolved at the time of service.
3	Authorization delays - Transaction delayed because the review process for authorization of the service was not completed/finalized at the time of service.
4	Delay in certifying provider– Transaction delayed because the provider certification for participation with the plan was not completed/finalized at the time of service.
5	Delay in supplying billing forms- Transaction delayed because specified billing form was not available at the time of service.
6	Delay in delivery of custom-made appliances - Transaction delayed because custom-fabricated appliance was not ready for delivery at the time related services/supplies were provided.
7	Third party processing delay– Transaction delayed because payment decision of third party payer(s) was not complete/received at the time of service.
8	Delay in eligibility determination– Transaction delayed because patient enrollment in benefit plan not complete at the time of service; or subsequent determination made enrollment retroactive to or prior to the date of service.
9	Original claims rejected or denied due to a reason unrelated to the billing limitation rules– Transaction delayed for correction of inadequacies or errors on previous, timely submitted claims.
1Ø	Administration delay in the prior approval process - Transaction delayed because the authorizing entity was unable to complete and/or provide the authorization prior to the time of service.
11	Other - Does not fit within any of the other delay reason codes
12	Received late with no exceptions
13	Substantial damage by fire, etc to provider records -Transaction delayed because damaged records of services had to be reconstructed in order to complete the transaction
14	Theft, sabotage/other willful acts by employee– Transaction delayed because of employee misconduct.

492-WE – Diagnosis Code Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Diagnosis Code' (424-DO).	x(2)	T, M, F,A	

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4 a Post Adjudication Standard Version 1 Value was deleted for use in higher versions of these standards.
ØØ	Not Specified	
Ø1	International Classification of Diseases (ICD9) - Code indicating the diagnosis is defined according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. Most codes are numeric and consist of 3, 4, or 5 numbers and a description. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services.	
Ø2	International Classification of Diseases-1Ø-Clinical Modifications (ICD-1Ø-CM) - Code indicating that the following information is a diagnosis as defined by ICD-1Ø-CM. As of January 1, 1999, the ICD-1Ø is used to code and classify mortality data from death certificates. The International Classification of Diseases, 1Øth Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. The codes are 3 to 7 digits with the first digit alpha, the second and third numeric and the remainder A/N. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services.	
Ø3	National Criteria Care Institute (NCCI) - The CMS-developed Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.	
Ø4	The Systematized Nomenclature of Human and Veterinary Medicine (SNOMED) - A clinical health care terminology and infrastructure that provides a common language that enables a consistent way of capturing, sharing and aggregating health data across specialties and sites of care.	
Ø5	Common Dental Terminology (CDT) - Current Dental Terminology (CDT) is the published Code on Dental Procedures and Nomenclature (the Code) providing descriptive terms, codes and guidance for the accurate reporting of dental procedures. The Code is maintained by the Code Revision Committee and published by the American Dental Association. The procedure codes and descriptions are also published as part of the Healthcare Common Procedure System (HCPCS) Level II through agreement with Centers for Medicare and Medicaid Services.	
Ø6	Medi-Span Product Line Diagnosis Code - Proprietary code used by Medi-Span product line to specify diagnosis	

CODE	DESCRIPTION	Value Limitations
Ø7	American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV) - Diagnostic criteria for the most common mental disorders including: description, diagnosis, treatment, and research findings. Comments: The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV) is published by the American Psychiatric Association, Washington D.C.	
Ø8	First DataBank Disease Code (FDBDX) Proprietary code used by First DataBank product line to specify diagnosis	
Ø9	First DataBank FML Disease Identifier (FDB DxID) - Proprietary code used by First DataBank product line to specify diagnosis	
99	Other - Different from those implied or specified	

6Ø6-NC – Discontinue Date Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying Discontinue Date (6Ø7-NC).	x(1)	V	

Values:

CODE	DESCRIPTION
Blank	Not Specified
A	System Calculated - This date will indicate the prescription's expiration date, i.e. a year from date of issue.
B	Prescriber Specified - A date indicated by the physician/ prescriber as the last day to fill the prescription. Beyond this date, the prescription is no longer valid.

4Ø8-D8 Dispense As Written (DAW)/ Product Selection Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	x(1)	C, D, R, T,A,V	

Values:

CODE	DESCRIPTION
Ø	No Product Selection Indicated - This is the field default value that is appropriately used for prescriptions for single source brand, co-branded/co-licensed, or generic products. For a multi-source branded product with available generic(s), DAW Ø is not appropriate, and may result in a reject.
1	Substitution Not Allowed by Prescriber – This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is Medically Necessary to be Dispensed As Written. DAW 1 is based on prescriber instruction and not product classification.
2	Substitution Allowed-Patient Requested Product Dispensed-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.
3	Substitution Allowed-Pharmacist Selected Product Dispensed-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available

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

343-HD – Dispensing Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory shortages do not allow the full quantity to be dispensed.	x(1)	T,A,R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted for use in higher versions of these standards.
P	Partial Fill - A dispensing of less than the prescribed quantity, the balance of which will be dispensed at a later time.	
C	Completion of Partial Fill - Dispensing the remaining quantity of a prescription when the entire amount could not be supplied at the original dispensing (fill).	

6Ø1-34 - Dosage Form ID Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Dosage form of product being	x(2)	R	For Medicaid/Government use only.

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
reported.			

Values:

	DESCRIPTION
AA	Aerosol (ML)
AB	Aerosol (GM)
AC	Aerosol (EA)
AD	Aerosol Refill (ML)
AE	Aerosol Refill (EA)
AF	Aerosol, Foam
AG	Aerosol Refill (GM)
AH	Aerosol with Adapter (ML)
AI	Aerosol with Adapter (EA)
AJ	Aerosol with Adapter (GM)
AK	Aerosol, Powder (EA)
AL	Ampul for Nebulization (ML)
AM	Aerosol, Mist
AN	Vial, Nebulizer
AO	Aerosol, Breath Activated
AP	Aerosol, Powder (GM)
AQ	Spray (GM)
AR	Spray Refill (ML)
AS	Aerosol, Spray (ML)
AT	Aerosol, Spray with Pump (ML)
AU	Spray, Non Aerosol (ML)
AV	Foam (ML)
AW	Aerosol, Foam with Applicator
CA	Capsule (Hard, Soft, etc.)
CB	Capsule, Sustained Release 12hr
CC	Capsule, Sustained Release 24hr
CE	Capsule, Enteric Coated
CK	Sprinkle Capsule
CP	Capsule, Sustained Release Pellets IN
CS	Capsule, Sustained Action
CT	Capsule, Degradable Controlled Release
EA	Each
EB	Bar
EC	Cake
ED	Soap, Medicated (EA)
EE	Soap, Liquid
EF	Dental Cone
EH	Stick
EJ	Plaster
EK	Poultice
EL	Swab, Medicated

	DESCRIPTION
EN	Tape, Medicated
EP	Soap, Medicated (ML)
ER	Soap, Medicated (GM)
ET	Pads, Medicated, (EA)
FI	Film, Medicated
GA	Gas
GH	Inhaler (ML)
GI	Inhaler (EA)
GJ	Inhaler Kit (EA)
GZ	Inhaler (GM)
HA	Infusion Bottle (EA)
HB	Infusion Bottle (ML)
HC	Pipette (EA)
HD	Pipette (ML)
HE	Allergen
HH	Ampul (ML)
HI	Cartridge (EA)
HJ	Cartridge (ML)
HK	Intravenous Solution Piggyback Premix Frozen (ML)
HM	Intravenous Solution
HN	Intravenous Solution, Piggyback (EA)
HP	Intravenous Solution, Piggyback (ML)
HQ	Disposable Syringe (ML)
HR	Ampul (EA)
HS	Vial (SDV, MDV or Additive) (EA)
HT	Skin Test
HU	Plastic Bag, Injection (EA)
HV	Vial (SDV, MDV or Additive) (ML)
HW	Additive Syringe
HX	Disposable Syringe (EA)
HY	Intraperitoneal Solution
HZ	Plastic Bag, Injection (ML)
JA	Jelly
JB	Jel (ML)
JC	Gel (ML)
JD	Jel (GM)
JE	Beads
JG	Gel (GM)
JH	Pudding (EA)
JJ	Pudding (GM)

	DESCRIPTION
JS	Gel-Forming Solution
JU	Gel with Pre-filled Applicator
JV	Gel with Applicator
JW	Jelly with Applicator
KA	Creams (GM)
KL	Lubricant
KM	Cream (ML)
KP	Paste
KT	Toothpaste
KV	Cream with Pre-filled Applicator
KW	Cream with Applicator
OA	Ointment
OB	Ointment (ML)
OV	Ointment with Pre-filled Applicator
OW	Ointment with Applicator
PA	Powder (GM)
PB	Leaves (GM)
PC	Crystals
PD	Reconstituted Suspension, Oral
PF	Flakes
PG	Granules; Powder-like, Non-effervescent
PH	Drops, Reconstituted, Oral
PI	Solution, Reconstituted, Oral
PJ	Suspension, Sustained Release 12hr
PK	Patch, Transdermal Weekly
PL	Cleanser (GM)
PM	Lump
PN	Cleanser (ML)
PP	Packet
PQ	Patch, Transdermal Bi-weekly
PR	Patch, Transdermal 72hr
PS	Adhesive Patch, Medicated
PT	Tooth Powder
PU	Powder (EA)
PV	Patch, Transdermal 24hr
QA	Suppository, Rectal
QB	Insert
QC	Suppository, Vaginal
RA	Solution (GM)
SA	Solution
SB	Fluid Extract
SC	Suspension, Oral (Final Dose Form) (ML)
SD	Douche
SE	Elixir
SF	Enema (ML)

	DESCRIPTION
SG	Enema (EA)
SH	Expectorant
SI	Liniment
SJ	Solution, Oral
SK	Lotion (ML)
SL	Liquid
SM	Mouthwash
SN	Suspension, Drops (Final Dosage Form) (ML)
SO	Drops
SP	Spirit
SQ	Oil
SR	Suspension, Topical
SS	Shampoo
ST	Syrup
SU	Emulsion
SV	Granules, Effervescent
SW	Solution, Irrigating
SX	Tincture
SY	Concentrate, Oral
SZ	Lotion (GM)
TA	Tablet (Compressed, Sugar Coated Caplets)
TB	Tablet, Soluble
TC	Tablet, Chewable
TD	Disk
TE	Tablet, Enteric Coated
TF	Tablet, Effervescent
TG	Gum
TH	Tablet, Hypodermic
TI	Tablet, Sustained Release 24hr
TJ	Tablet, Dispersable
TK	Gum (GM)
TL	Lozenge
TM	Tablet, Sustained Release 12hr
TN	Granules, Oral Tablet-like or Packets
TP	Pellet
TR	Tablets, Particles/Crystals in
TS	Tablet, Sustained Action
TT	Troche
TU	Tablet, Sublingual
TV	Tablet, Buccal
TW	Wafer
TX	Pill
TY	Tablet, Buccal Sustained Action

	DESCRIPTION
TZ	Tablet, Osmotic Laser-Drilled Form
UN	Unit
WH	Whip
YA	Needle, Re-usable
YB	Bulk
YC	Syringe, Re-usable
YD	Diaphragm
YE	Bandage
YF	Lenses
YH	Needle, Disposable
YI	Intrauterine Device (IUD)
YJ	Syringe, Cornwall
YK	Kit
YL	Syringe, Empty Disposable
YM	Pad
YN	Tampon
YP	Intraperitoneal Admin. Sets - Paraphernalia
YQ	Intravenous Admin. Sets - Paraphernalia
YR	Strip
YS	Suture
YT	Tape
YU	Irrigation Set
YV	Sponge
YW	Swab, Non-Medicated
YX	Intravenous Admixture Accessories
YY	Refill Kit (EA)
YZ	Blood Administration Set
ZA	Miscellaneous
ZB	Box
ZC	Bottle
ZD	Combination Package
ZE	Carton
ZP	Package
ZT	Tray
ØØ	Miscellaneous
Ø1	Capsules
Ø2	Capsules Controlled Release
Ø3	Tablets
Ø4	Tablets Controlled Release
Ø5	Chewable
Ø6	Enteric Coated Tablets
Ø7	Sublingual Tablets
Ø8	Effervescent Tablets
Ø9	Liquid

	DESCRIPTION
1Ø	Elixir
11	Liquid Controlled Release
12	Syrup
13	Concentrate
14	Extract
15	Tincture
16	Emulsion
17	In Oil
18	Suspension
19	Suspension for Reconstitution
2Ø	Solution
21	Solution for Reconstitution
22	Injection
23	Implant
24	Inhalation
25	Nebulizer Solution
26	Gas
27	Granules
28	Gum
29	Powder
3Ø	Powder Packet
31	Wafer
32	Aerosol
33	Aerosol Powder
34	Aerosol Solution
35	Bar
36	Beads
37	Cream
38	Crystals
39	Foam
4Ø	Gel
41	Lotion
42	Ointment
43	Pad
44	Paste
45	Shampoo
46	Tape
47	Lozenge
48	Troche
49	Whip
5Ø	Ocular System
51	Enema
52	Suppository
53	IUD
54	Diaphragm

	DESCRIPTION
55	Douche
56	Douche Powder
57	Douche Solution
58	Tampon
59	Transdermal System

	DESCRIPTION
6Ø	Test
61	Strip
62	Device
63	Miscellaneous
64	Kit

914-B5 - Drug Qualifier-Step Drug

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates whether the Product/Service ID represents a specific medication versus a pharmacological class.	x(2)	F	

Values:

CODE	DESCRIPTION
SM	Specific Medication – Indicates that the step therapy list is defined by a specific drug vs. a therapy class of drugs.
PC	Pharmacological Class – Indicates that the step therapy list is defined by a therapy class of drugs vs. a specific drug.

916-B7 - Drug Reference Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code value that identifies the source and type for the Drug Reference Number.	x(3)	F	

Values:

CODE	DESCRIPTION
See Section II, Appendix B2 – Drug Reference Values.	

918-B9 - Drug Reference Qualifier -Alternative

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code value that identifies the source and type for the Drug Reference Number -Alternative.	x(3)	F	

Values:

CODE	DESCRIPTION
See Section II, Appendix B2 – Drug Reference Values.	

92Ø-CT - Drug Reference Qualifier -Source

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code value that identifies the source and type for the Drug Reference Number -Source.	x(3)	F	

Values:

CODE	DESCRIPTION
See Section II, Appendix B2 –Drug Reference Values.	

922-CV - Drug Reference Qualifier -Step Drug

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code value that identifies the source and type for the Drug Reference Number -Step Drug.	x(3)	F	

Values:

CODE	DESCRIPTION
See Section II, Appendix B2 – Drug Reference Values.	

425-DP – Drug Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code to indicate the type of drug dispensed.	9(1)	C, D, P, A	

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Single Source — a clinical formulation that is only available from a single distributor.
2	Authorized Generic (aka “Branded Generic”)—the originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. e.g. Pfizer and its subsidiary Greenstone.
3	Generic— the pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA).
4	Over the Counter— drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: “Caution: Federal Law Prohibits Dispensing Without a Prescription.”
5	Multi-source Brand—product’s clinical formulation is available from multiple distributors

475-J9 – DUR Co-Agent ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the value in ‘DUR Co-Agent ID’ (476-H6).	x(2)	T.A,S	

Values:

CODE	DESCRIPTION
See Section II, Appendix B1 – Product/Service Qualifier	

474-8E - DUR/PPS Level Of Effort

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the level of effort as	9(2)	T,A	

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.			

Values:

CODE	DESCRIPTION
Ø	Not Specified
11	Level 1 (Lowest)
12	Level 2
13	Level 3
14	Level 4
15	Level 5 (Highest)

6Ø8-NF – Easy Open Cap Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating patient requires use of easy open cap or not.	x(1)	V	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	No
2	Yes

3Ø9-C9 – Eligibility Clarification Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating that the pharmacy is clarifying eligibility for a patient.	9(1)	C, D, P, T,A	

Values:

CODE	DESCRIPTION
Ø	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

245 – Eligibility COB Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Coordination of Benefits code as provided on Client eligibility.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Payer is primary – Plan is first payer for patient
2	Payer is secondary – Plan is second payer for patient
3	Payer is tertiary - Plan is third payer for patient

247 – Eligibility/Patient Relationship Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Individual Relationship Code. Code indicating the relationship between two individuals or entities.	9(2)	A	

Values:

CODE	DESCRIPTION
ØØ	Not Applicable
Ø1	Spouse
Ø3	Father or Mother
Ø4	Grandfather or Grandmother
Ø5	Grandson or Granddaughter
Ø6	Uncle or Aunt
Ø7	Nephew or Niece
Ø8	Cousin
Ø9	Adopted Child
1Ø	Foster Child
11	Son-in-law or Daughter-in-law
12	Brother-in-law or Sister-in-law
13	Mother-in-law or Father-in-law
14	Brother or Sister
15	Ward
17	Stepson or Stepdaughter
18	Self
19	Child
23	Sponsored Dependent
24	Dependent of a Minor Dependent
25	Ex-spouse
26	Guardian
31	Court Appointed Guardian
32	Mother
33	Father
38	Collateral Dependent
48	Stepfather
49	Stepmother
53	Life Partner

248 – Eligible Coverage Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Coverage Level Code. Code indicating the level of coverage being provided for the insured.	x(3)	A	

Values:

CODE	DESCRIPTION
CHD	Children Only
DEP	Dependents Only
E1D	Employee and One Dependent
E2D	Employee and Two Dependents
E3D	Employee and Three Dependents
E5D	Employee and One or More Dependents
E6D	Employee and Two or More Dependents
E7D	Employee and Three or More Dependents
E8D	Employee and Four or More Dependents
E9D	Employee and Five or More Dependents
ECH	Employee and Children
EMP	Employee Only
ESP	Employee and Spouse
FAM	Family
IND	Individual
SPC	Spouse and Children
SPO	Spouse Only
TWO	Two Party – Coverage for only two people

6ØØ-69 - Eligible Plan

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates whether or not the plan is eligible for rebates.	x(1)	R	

Values:

CODE	DESCRIPTION
N	No
Y	Yes

782 - Entity State

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
State in which the entity indicated is located.	x(2)	M	

Values:

CODE	DESCRIPTION
See Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

318-CI - Employer State/ Province Address

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Standard State/Province code as defined by appropriate government agency.	x(2)	T	

Values:

CODE	DESCRIPTION
See Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

387-3V - Facility State/Province Address

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Standard State/Province code as defined by appropriate government agency.	x(2)	T	Used in Telecommunication Standard Version C.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

25Ø – FDA Drug Efficacy Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø	Was Drug Efficacy Study Implementation (DESI) At One Time But No Longer
1	Drug Efficacy Study Implementation (DESI) Drug

251 – Federal Upper Limit Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates if a Federal Upper Limit exists for the drug.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Yes

CODE	DESCRIPTION
2	No

252 – Federal DEA Schedule

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The controlled substance schedule as defined by the Drug Enforcement Administration.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Schedule I Substance (no known use)
2	Schedule II Narcotic Substances
3	Schedule III Narcotic Substances
4	Schedule IV Substances
5	Schedule V Substances

6Ø1-38 - FF Prescriber ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of data being submitted in the 'Prescriber ID' (411-DB) field.	x(1)	R	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Field was deleted in Manufacturer Rebates Standard Version Ø4.Ø1.

Values:

CODE	DESCRIPTION
A	American Medical Association (AMA) Medical Education (ME) number
B	American Osteopathic Association (AOA) Doctor of Osteopathy (DO) number
C	Contracting organization (PMO) assigned ID number
D	DEA number
H	HIBCC HIN
M	Manufacturer (PICO) assigned ID number
P	National Provider ID (NPI)
T	Telephone number
Z	Mutually agreed upon ID number

611-NJ – File Structure Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates type of structure of record supported.	9(1)	V	

Values:

CODE	DESCRIPTION

CODE	DESCRIPTION
Ø	Not Specified
1	Fixed Length Record - Each record type is a fixed length size
2	Variable Length Record - Each record type may vary in length

7Ø2-MC – File Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying whether the file contained is test or production data.	x(1)	B, M, F,A,V	

Values:

CODE	DESCRIPTION
T	Test - In processing systems, the test environment.
P	Production – In processing systems, the live environment.

4Ø3-D3 Fill Number

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The code indicating whether the prescription is an original or a refill.	9(2)	T,A,R,V	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
Ø	Original dispensing - The first dispensing
1-99	Refill number - Number of the replenishment

254 – Fill Number Calculated

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying whether the prescription is an original (ØØ) or by refill number (Ø1-99) as calculated by system based on historical claims data. This field represents the Fill Number as calculated (not submitted by pharmacy)	9(2)	A	

Values:

CODE	DESCRIPTION
ØØ	New - Original
Ø1-99	Refill number - Number of the replenishment

924-DH - First Copay Term

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
First Copay term (flat copay amount or percent copay) to be	x(1)	F	

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
considered			

Values:

CODE	DESCRIPTION
F	Flat Copay – A code indicating the patient responsibility is based on a preset value for the corresponding drug type.
P	Percent Copay – A code indicating the patient responsibility is based on a computed percentage for the corresponding drug type.

6ØØ-73 - Formulary Benefit Design Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of formulary benefit design utilized by the plan.	x(4)	R	

Values:

CODE	DESCRIPTION
1Ø1Ø	OPEN=A pharmaceutical benefit utilized by members of a plan or organization that does not restrict reimbursement or implement intervention against pharmaceutical products in a plan or organization formulary.
1Ø2Ø	CLOSED=A pharmaceutical benefit utilized by members of a plan or organization that restricts reimbursement to pre-identified pharmaceutical products.
1Ø3Ø	CHOICE=Choice with no specific type of control.
1Ø4Ø	LIMITED=A pharmaceutical benefit utilized by members of a plan or organization that restricts reimbursement for certain branded pharmaceutical products, or implements interventions against certain branded pharmaceutical products.
1Ø41	STANDARD LIMITED=Limited with Standard Control.
1Ø42	BENEFIT LIMITED=Limited with Benefit Control.
1Ø43	CLOSED LIMITED=Limited with Closed Control.
1Ø5Ø	PARTIAL CLOSED=A pharmaceutical benefit utilized by members of a plan or organization that restricts reimbursement of pre-defined pharmaceutical products within specific therapeutic classes or other categories.
1Ø6Ø	RESTRICTED=List of pharmaceutical products that are available for use in treating their patients within an institution or healthcare financing system. Restrictive formularies limit prescribing and reimbursement to only certain pharmaceutical products.
1Ø7Ø	PREFERRED=Preferred means available on a pharmaceutical formulary in a manner such that the product is given preference in dispensing decisions over competing products in a therapeutic class or therapeutic use.
1Ø71	STANDARD PREFERRED=Preferred with Standard Control.
1Ø72	BENEFIT PREFERRED=Preferred with Benefit Control.
1Ø73	CLOSED PREFERRED=Preferred with Closed Control.
1Ø8Ø	EXCLUSIVE=Exclusive means available on a pharmaceutical formulary in a manner such that it is the only product included on the formulary in its therapeutic class, and no competing products in its therapeutic class are reimbursed or dispensed.
1Ø81	STANDARD EXCLUSIVE=Exclusive with Standard Control.
1Ø82	BENEFIT EXCLUSIVE=Exclusive with Benefit Control.
1Ø83	CLOSED EXCLUSIVE=Exclusive with Closed Control.
1Ø9Ø	EXPANDED=Expanded with no specific type of control.
1Ø91	STANDARD EXPANDED=Expanded with Standard Control.

CODE	DESCRIPTION
1Ø92	BENEFIT EXPANDED=Expanded with Benefit Control.
1Ø93	CLOSED EXPANDED=Expanded with Closed Control.
99Ø1	OTHER= Any other types not covered by definitions above. New codes, definitions and descriptions should be developed for anything classified as "Other".
9999	NOT CLASSIFIED

6ØØ-76 Formulary Non-Formulary Co-Pay Confidential

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates whether or not the co-pay is confidential; does not imply that the formulary non-formulary co-pay amounts are reported.	x(1)	R	

Values:

CODE	DESCRIPTION
N	No
Y	Yes

6Ø1-17 Formulary Product Co-Pay Confidential

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates whether the co-pay is confidential or not; does not imply that the formulary product co-pay is reported.	x(1)	R	

Values:

CODE	DESCRIPTION
N	No
Y	Yes

927-FP - Formulary Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Status of the drug within the formulary.	x(2)	F	

Values:

CODE	DESCRIPTION
A	Any
U	Unknown
Ø	Not Reimbursable – A message from the processor to the pharmacist that the medication submitted on the claim is not on the list of payable products in that patient's plan formulary.
1	Non Formulary- Response code indicating that the prescribed drug is not included in the plan formulary.
2	On Formulary (Not Preferred) – A message from Processor to the pharmacist that the medication submitted on the claim is included in the list of payable products in that patient's plan formulary but that there is a more preferred product in the therapeutic category.

CODE	DESCRIPTION
3	Preferred Level 1- Level of preferences for the formulary drug listed. The higher the number for the preferred level, the more preferred the drug is. Value = 1, least preferred level.
4	Preferred Level 2- Level of preferences for the formulary drug listed. The higher the number for the preferred level, the more preferred the drug is.
5	Preferred Level 3- Level of preferences for the formulary drug listed. The higher the number for the preferred level, the more preferred the drug is.
6-99	Preferred Levels 4 through 99 - Level of preferences for the formulary drug listed. The higher the number for the preferred level, the more preferred the drug is. Values=4 through 99 with 99 being the most preferred level.

257 - Formulary Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the Formulary status of the Drug.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
I	Drug on Formulary; Non-Preferred - The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category.
J	Drug not on Formulary; Non-Preferred - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category.
K	Drug not on Formulary; Preferred - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice.
N	Drug not on Formulary; Neutral - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.
P	Drug on Formulary - The medication submitted on the claim is included in the list of products in that patient's plan formulary.
Q	Drug not on Formulary - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary.
T	Drug on Formulary; Preferred- Therapeutic interchange occurred on this claim - The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product.
Y	Drug on Formulary; Neutral - The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.

721-MD Gender Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the gender of the individual.	x(1) 9(1)	F A	

Values:

CODE	DESCRIPTION

CODE	DESCRIPTION
Blank	Unknown
1	Male
2	Female

125-TZ – Generic Equivalent Product ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Generic Equivalent Product ID' (126-UA).	X(2)	T	Used in Telecommunication Standard Version D.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Section II, Appendix B1 – Product/Service Qualifier	

5Ø1-F1 – Header Response Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the status of the transmission.	x(1)	T,N	

Values:

CODE	DESCRIPTION
A	Accepted - Code indicating the receipt and approval of the transmission.
R	Rejected - Code indicating the rejection or refusal to accept the transmission.

549-7F - Help Desk Phone Number Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the phone number in the 'Help Desk Phone Number' (55Ø-8F).	x(2)	T	

Values:

CODE	DESCRIPTION	Value Limitation
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in higher versions.
Ø1	Switch – An entity that accepts an electronic transaction from another organization and electronically routes the transaction to a receiving entity. A switch may perform value added services including detailed editing/messaging of input/output data for validity and accuracy and translating data from one format to another.	
Ø2	Intermediary-A code indicating an organization that intercepts a request (or reply), performs a value-added function and then forwards the enhanced request (or reply) to the original target.	
Ø3	Processor/PBM – Entity that processes the data submitted by a provider of pharmacy services for the purpose of receiving eligibility and coverage determination and/or payment.	

CODE	DESCRIPTION	Value Limitation
99	Other –Different from those implied or specified	

612-NK – Inactive Prescription Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates that the prescription is considered inactive and is therefore no longer fillable.	x(1)	V	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Y	Prescription is inactive - Prescription is not refillable
N	Prescription is active - Prescription is not inactive and is therefore refillable, of remaining refills exist

266 – In Network Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates if the pharmacy dispensing the prescription is considered in network.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Y	In Network – The dispensing pharmacy was under contract with the plan to provide services
N	Out of Network – The dispensing pharmacy was not under contract with the plan

463-EW – Intermediary Authorization Type ID

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Value indicating that authorization occurred for intermediary processing.	9(2)	T	

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Intermediary Authorization – Code for a service that intercepts a request (or reply), performs a value-added function and then forwards the enhanced request (or reply) to the original target
99	Other Override – A value different from those specified that indicates exception processing.

17Ø-WB – Invoice Type 1

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Description of transaction type.	X(3)	R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
ØØ1	Administrative Fee – A fee for services to manage or supervise the execution of a contractual agreement between parties, calculated as agreed to between parties or further defined via the contract document between trading partners.
ØØ2	Aggregate Formulary – The entire formulary as a whole calculated as agreed to between parties or further defined via the contract document between trading partners.
ØØ3	Aggregate Therapeutic Market Share – The total drug utilization for a defined therapeutic class of drugs, calculated as agreed to between parties or further defined via the contract document between trading partners.
ØØ4	Baseline Market Share – A rebate type that is based upon a prior period's market share performance (baseline). The period to be used as the baseline and the calculation method as agreed to between parties or further defined via the contract document between trading partners.
ØØ5	Compliance Rebate - The type of rebate payment requested by the PMO of the PICO where the Performance Qualifier is CR (Compliance) calculated as agreed to between parties or further defined via the contract document between trading partners.
ØØ6	Discount Price Guarantee-The type of rebate payment requested by the PMO of the PICO where the rebate amount is calculated using a fixed price for all units dispensed. The fixed price is a price guarantee offered by the PICO to the PMO calculated as agreed to between parties or further defined via the contract document between trading partners.
ØØ7	Dollar Volume-The total dollar amount paid for a given drug or drug class in a given period of time, calculated as agreed to between parties or further defined via the contract document between trading partners.
ØØ8	Dosage Guarantee-The type of rebate payment requested by the PMO of the PICO where the rebate amount is calculated based upon the number of units dispensed or market share percentage of a certain product's dosage. The rebate amount to be paid for the number of units dispensed at a certain dose or the market share to be achieved at a certain dosage calculated as agreed to between parties or further defined via the contract document between trading partners.
ØØ9	Fixed Discount- Term used to identify the type of rebate (discount) negotiated between trading partners. The fixed discount is a predetermined or set amount that is independent of volume or market share (also knows as flat rebate), calculated as agreed to between parties or further defined via the contract document between trading partners.
Ø1Ø	Individual Formulary – Rebate calculation based on the performance of a specific formulary such as open, closed, restricted, etc. calculated as agreed to between parties or further defined via the contract document between trading partners.
Ø11	Individual Therapeutic Market Share–A market share rebate calculation for a given product(s) based on the performance of that product within a specific therapeutic class, calculated as agreed to between parties or further defined via the contract document between trading partners.
Ø12	Market Share-Used to determine the calculation of a rebate based upon a contractual specification, the market share is a measure of the product's relative contribution to the whole of similar products. Market share is a ratio of the product(s) in question over the entire product basket, expressed as a percentage calculated as agreed to between parties or further defined via the contract document between trading partners.
Ø13	National Market Share- Refers to a benchmark market share percentage, as measured on a national average basis, for the product's share of the total of all products within the product category in which it competes, calculated as agreed to between parties or further defined via the contract document between trading partners.
Ø14	Per Member Per Month (PMPM) – Rebates are calculated monthly using a fixed amount for each member in the plan, calculated as agreed to between parties or further defined via the contract document between trading partners.
Ø15	Per Member Per Quarter (PMPQ) - Rebates are calculated quarterly using a fixed amount for each member in the plan, calculated as agreed to between parties or further defined via the contract document between trading partners.
Ø16	Per Member Per Year (PMPY) - Rebates are calculated annually using a fixed amount for each member in the plan, calculated as agreed to between parties or further defined via the contract

CODE	DESCRIPTION
	document between trading partners.
Ø17	Performance-Based – Rebates are determined based on performance indicators such as sales growth, compliance, or market share, etc., calculated as agreed to between parties or further defined via the contract document between trading partners.
Ø18	Risk Share - Used to describe a category of rebate in which both parties associated with the rebate or discount agreement agree to performance incentives, including the willingness to share the risk of some objectively measurable financial gain or loss, calculated as agreed to between parties of further defined via the contract document between trading partners.
Ø19	Standard Dollar – A rebate type that is paid based upon a standard definition of volume, calculated as agreed to between parties or further defined via the contract document between trading partners.
Ø2Ø	Unit Volume – A rebate that is paid based upon an objectively measured unit volume reported by the contracting entity, may be payable per unit, as long as the use of the product meets or exceeds a threshold, calculated as agreed to between parties or further defined via the contract document between trading partners.
Ø21	Volume Fixed Discount – The rebate is a pre-determined fixed amount dependent on the volume calculated as agreed to between parties or further defined via the contract document between trading partners.
Ø22	Volume Tier – The rebate is an amount dependant on volume tier(s), calculated as agreed to between parties of further defined via the contract document between trading partners.
Z_	Mutually Agreed Upon Rebate Types (All codes beginning with the letter Z are reserved for use between trading partners.)- A Rebate type (fixed, market share, etc.) mutually agreed upon by trading partners to define the rebate.

171-WC – Invoice Type 2

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Description of transaction type.	X(3)	R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Invoice Type 1 (17Ø-WB) values	

172-WD – Invoice Type 3

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Description of transaction type.	X(3)	R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Invoice Type 1 (17Ø-WB) values	

173-WF – Invoice Type 4

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Description of transaction type.	X(3)	R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
			versions.

Values:

CODE	DESCRIPTION
See Invoice Type 1 (17Ø-WB) values	

174-WG – Invoice Type 5

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Description of transaction type.	X(3)	R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Invoice Type 1 (17Ø-WB) values	

371-2S - Length of Need Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the length of need.	9(2)	T	Used in Telecommunication Standard Version C.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Hours – Units of time composed of 60 minutes; there are 24 in one day
2	Days – Units of time composed of 24 consecutive hours
3	Weeks – Units of time composed of 7 consecutive days
4	Months – Units of time composed of 28 to 31 days; there are 12 in one year
5	Years – Units of time composed of 12 months; also equivalent to 365 days (366 days in leap years)
6	Lifetime – An imprecise time reference that equates to the perceived time remaining until either the end of the patient's life or the useful duration of the product referenced by the claim

418-DI – Level of Service

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Coding indicating the type of service the provider rendered.	9(2)	P, T,A	

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Patient consultation—professional service involving provider/patient discussion of disease, therapy or medication regimen, or other health

CODE	DESCRIPTION
	issues
2	Home delivery—provision of medications from pharmacy to patient's place of residence
3	Emergency—urgent provision of care
4	24 hour service—provision of care throughout the day and night
5	Patient consultation regarding generic product selection—professional service involving discussion of alternatives to brand-name medications
6	In-Home Service—provision of care in patient's place of residence

928-FR - List Action

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates whether this is a replacement list, list updates or a list delete	x(1)	F	

Values:

CODE	DESCRIPTION
F	Full Replace – All data previously provided (if any) is replaced with the current data; if no prior data exists, the current data is added
D	Delete – All data previously provided is deleted and no replacement data is provided
U	Update – Previously provided data is amended or replaced by the current data

93Ø-F2 - Load Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates whether this is a replacement list, list updates or a list delete	x(2)	F	

Values:

CODE	DESCRIPTION
Ø1	File loaded correctly - Process whereby a computer manipulates a string of bytes without error.
Ø2	File loaded with errors - Process whereby a computer manipulates a string of bytes that contains inaccuracies.
Ø3	File contains errors - File Not loaded - Process whereby a computer could not manipulate a string of bytes with errors.
Ø4	An error has occurred during processing not related to the structure of the file – Process whereby a computer manipulates a string of bytes and performs some type of validation that detects a mistake in that data.

272 – MAC Reduced Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates if a claim payment was reduced due to a MAC (Maximum	x(1)	A	

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Allowable Cost) program.			

Values:

CODE	DESCRIPTION
Blank	Not Specified
Y	Reduced to MAC pricing
N	Not reduced to MAC pricing

6ØØ-81 - Mail Order ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of data being submitted in the 'Mail Order ID Code' (6ØØ-8Ø) field.	x(1)	R	

Values:

CODE	DESCRIPTION
C	Contracting organization (PMO) assigned ID number - Alphanumeric code used to identify the PMO that sent a NCPDP manufacturer rebate flat file standard layout to a PICO. This code is an internal number assigned by the PMO.
D	DEA number - The number assigned by the DEA to all businesses that manufacturer or distribute controlled pharmaceuticals, all health professionals who dispense, administer, or prescribe controlled pharmaceuticals an all pharmacies that fill prescriptions.
F	Federal Tax ID Number –– A 9-digit number assigned by the Internal Revenue Service to sole proprietors, corporations, partnerships, estates, trusts, and other entities for the purpose of tax filing and reporting.
H	HIBCC 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.
M	Manufacturer (PICO) assigned ID number- A value assigned by a manufacturer and used internally to identify a given trading partner.
P	National Provider ID (NPI) –A HIPAA-mandated standard unique health identifier for health care providers
T	Telephone number - Code indicating that the information to follow is a telephone number (for voice, data, fax, etc.).
Z	Mutually agreed upon ID number- A value mutually agreed upon by trading partners to identify a given data element. The value may be unique between the trading partners or from an existing industry standard.

273 – Maintenance Drug Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates if the drug is a maintenance drug under the client's benefit plan.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Y	Maintenance Drug - Medication used to treat a chronic condition.
N	Not Maintenance - Medication used to treat an acute condition.

6ØØ-72 - Manufacturer (PICO) ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the type of data being submitted in the 'Manufacturer (PICO) ID Code' (6ØØ-48) field.	x(2)	R	Used in Manufacturer Rebates Standard Version Ø4.Ø1 or greater but not in lower versions. For Manufacturer Rebates Standard Version Ø3.Ø2 only the old field name of FF Manufacturer (PICO) ID Qualifier must be used.

Values:

CODE	DESCRIPTION
C	Contracting organization (PMO) assigned ID number - Alphanumeric code used to identify the PMO that sent a NCPDP manufacturer rebate flat file standard layout to a PICO. This code is an internal number assigned by the PMO.
D	DEA number - The number assigned by the DEA to all businesses that manufacturer or distribute controlled pharmaceuticals, all health professionals who dispense, administer, or prescribe controlled pharmaceuticals an all pharmacies that fill prescriptions.
F	Federal Tax ID number - A 9-digit number assigned by the Internal Revenue Service to sole proprietors, corporations, partnerships, estates, trusts, and other entities for the purpose of tax filing and reporting.
H	HIBCC 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.
L	NDC labeler code- The first five digits of the 5-4-2 formatted NDC code.
M	Manufacturer (PICO) assigned ID number- A value assigned by a manufacturer and used internally to identify a given trading partner.
T	Telephone number - Code indicating that the information to follow is a telephone number (for voice, data, fax, etc.).
Z	Mutually agreed upon ID number - A value mutually agreed upon by trading partners to identify a given data element. The value may be unique between the trading partners or from an existing industry standard.

931-F8 - Maximum Age Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the maximum age.	x(1)	F	

Values:

CODE	DESCRIPTION
D	Days – Age described in complete units of 24-hour periods
Y	Years – Age described in complete units of 12-month periods

934-GC - Maximum Amount Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
This field qualifies the amount in the Maximum Amount (933-GB).	x(2)	F	

Values:

CODE	DESCRIPTION

CODE	DESCRIPTION
DL	Dollar Amount – The value in the Maximum Amount field is expressed in United States currency.
DS	Days Supply – the value in the Maximum Amount field is expressed in the total number of days over which the prescription is intended to be consumed by the patient
FL	Fills - the value in the Maximum Amount field is expressed in the total number of times that the patient obtains the prescription including the original dispensing and all subsequent dispensing under that same Rx number.
QY	Quantity - the value in the Maximum Amount field is expressed in a numeric count of the number of billing units

935-GF - Maximum Amount Time Period

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Type of time period associated with the overall Maximum Amount Qualifier (934-GC).	x(2)	F	

Values:

CODE	DESCRIPTION
CM	Calendar Month – Specifically, the time elapsed from the start of the first day of a month until the end of the last day of that same month; frequently accepted as a period beginning with a specific event on the Nth day of a month and ending at the end of the day prior to the Nth day of the next month
CQ	Calendar Quarter – Specifically, the time elapsed from the start of the first day of a month until the end of the last day of the second month that follows; traditionally these periods start on the first day of the months of January, April, July and October
CY	Calendar Year – Specifically, the time elapsed from the start of the first day of a year until the end of the last day of that same year; frequently accepted as a period beginning with a specific event on the Nth day of a year and ending at the end of the day prior to the Nth day of the next year
DY	Days – Units of time composed of 24 consecutive hours
LT	Lifetime – An imprecise time reference that equates to the perceived time remaining until either the end of the patient's life or the useful duration of a product referenced
PD	Per Dispensing – An imprecise time reference that equates to the perceived time between dispensing events
SP	Specific Date Range – A specific period of time, as qualified by start and end dates

496-H2 - Measurement Dimension

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the clinical domain of the observed value in 'Measurement Value' (499-H4).	x(2)	T	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø1	Blood Pressure (BP)—amount of pressure (measured in millimeters of mercury) exerted by blood on vascular walls with each heart beat
Ø2	Blood Glucose—laboratory test measuring the amount of sugar (in grams per deciliter) in blood
Ø3	Temperature—degree of heat generated by the body

CODE	DESCRIPTION
Ø4	Serum Creatinine (SCr)—laboratory test measuring kidney function
Ø5	Glycosylated Hemoglobin (HbA1c)—laboratory test to measure the level of glucose in the blood over a defined period of time
Ø6	Sodium (Na+)—laboratory test measuring the amount of this electrolyte in blood or other body fluids
Ø7	Potassium (K+)— laboratory test measuring the amount of this electrolyte in blood or other body fluids
Ø8	Calcium (Ca++)— laboratory test measuring the amount of this electrolyte in blood or other body fluids
Ø9	Serum Glutamic-Oxaloacetic Transaminase (SGOT)—laboratory test measuring liver function
1Ø	Serum Glutamic-Pyruvic Transaminase (SGPT)—laboratory test measuring liver function
11	Alkaline Phosphatase—laboratory test measuring liver function
12	Theophylline—laboratory test measuring the amount of this drug in blood
13	Digoxin—laboratory test measuring the amount of this drug in blood
14	Weight—physical measure of bone, muscle, fluids and fat
15	Body Surface Area (BSA)—measured or calculated surface of the human body
16	Height—physical measure of stature
17	Creatinine Clearance (CrCl)—laboratory test measuring kidney function
18	Cholesterol—laboratory test measuring the amount of this fatty substance in the body
19	Low Density Lipoprotein (LDL) —laboratory test measuring the amount of this fatty substance in the body
2Ø	High Density Lipoprotein (HDL) —laboratory test measuring the amount of this fatty substance in the body
21	Triglycerides (TG) —laboratory test measuring the amount of this fatty substance in the body
22	Bone Mineral Density (BMD T-Score)—X-ray test measuring the structural integrity of bone skeleton
23	Prothrombin Time (PT)—laboratory test measuring the amount of time required for blood to clot
24	Hemoglobin (Hb; Hgb)—laboratory test measuring the amount of oxygen-carrying capacity of red blood cells
25	Hematocrit (Hct)—laboratory test measuring the volume percentage of erythrocytes in whole blood
26	White Blood Cell Count (WBC)—laboratory test measuring the number of leucocytes in whole blood
27	Red Blood Cell Count (RBC)—laboratory test measuring the number of erythrocytes in whole blood
28	Heart Rate—the number times the heart beats per minute
29	Absolute Neutrophil Count (ANC)—the number of white blood cells that are neutophils
3Ø	Activated Partial Thromboplastin Time (APTT)—laboratory test measuring the amount of time for blood to clot
31	CD4 Count—(also T4 Count, T-helper cells) laboratory test measuring the immune system's strength
32	Partial Thromboplastin Time (PTT)—laboratory test measuring the amount of time for blood to clot
33	T-Cell Count—laboratory test measuring the number of white blood cells that are T-cells
34	INR-International Normalized Ratio—laboratory test measuring the ratio of a patient's prothrombin time to a normal (control)
99	Other

497-H3 - Measurement Unit

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the metric or English units used with the clinical information.	x(2)	T	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø1	Inches (In)—measure of length; 1/12th of a foot
Ø2	Centimeters (cm)—measure of length; 1/100th of a meter

CODE	DESCRIPTION
Ø3	Pounds (lb)—measure of weight or mass; equal to 16 ounces
Ø4	Kilograms (kg)—measure of weight or mass; equal to 1000 grams
Ø5	Celsius (C)—measure of temperature
Ø6	Fahrenheit (F)—measure of temperature
Ø7	Meters squared (m2)—measure of area in length times width
Ø8	Milligrams per deciliter (mg/dl)—measure of mass in 100 milliliters
Ø9	Units per milliliter (U/ml)—measure of volume in 1 milliliter
1Ø	Millimeters of mercury (mmHg)—measure of force, as in blood pressure
11	Centimeters squared (cm2)—measure of area, as in body surface area
12	Milliliters per minute (ml/min)—measure of volume per unit of time
13	Percent (%)—amount per 100
14	Milliequivalents per milliliter (mEq/ml)—measure of the concentration of a substrate in one milliliter of fluid
15	International units per liter (IU/L)—measure of volume in one liter of fluid
16	Micrograms per milliliter (mcg/ml)—measure of mass in one milliliter of fluid. One microgram = 1 millionth of a gram
17	Nanograms per milliliter (ng/ml)—measure of mass in one milliliter of fluid. One nanogram = 1 billionth of a gram
18	Milligrams per milliliter (mg/ml)—measure of mass in one milliliter of fluid. One milligram = 1 thousandth of a gram
19	Ratio—measurement of the quantity of one substance or entity in relation to that of another; expressed as the quotient of one divided by the other
2Ø	SI Units—The International System of Units. Founded on seven SI base units for seven base quantities: length (meter), mass (kilogram), time (second), electric current (ampere), thermodynamic temperature (kelvin), amount of substance (mole), and luminous intensity (candela).
21	Millimoles/liter (mmol/l)—measure of mass in one liter of fluid
22	Seconds—measure of time; Equal to one 60th of an hour
23	Grams per deciliter (g/dl)—measure of mass per 100 milliliters
24	Cells per cubic millimeter (cells/cu mm)—number of units (cells) in 0.001 milliliters of fluid
25	1,ØØØ,ØØØ cells per cubic millimeter (million cells/cu mm)—measure of the number of units (cells) in 0.001 milliliters of fluid
26	Standard deviation—measure of the spread of values in a set
27	Beats per minute—the number of occurrences in one minute, as in heart rate.

36Ø-2B – Medicaid Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Two character State Postal Code indicating the state where Medicaid coverage exists.	x(2)	T	Used in Telecommunication Standard Version C.2 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Section II, Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

139-UR – Medicare Part D Coverage Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the position of Medicare Part D in the billing order.	9(2)	T	Used in Telecommunication Standard Version D.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
1	Primary – First
2	Secondary – Second
3	Tertiary - Third
4	Quaternary – Fourth
5	Quinary – Fifth
6	Senary - Sixth
7	Septenary – Seventh
8	Octonary – Eighth
9	Nonary – Ninth

274 – Medicare Plan Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
This represents if the member is eligible for Medicare coverage as provided in eligibility data.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
A	Medicare Part A - Part of the Original Medicare Plan managed by the federal government. Covers some, but not all, of the expenses incurred for inpatient hospital care or medical care that a person may receive at a skilled nursing facility (not a custodial care facility). Some hospice care and some home health care are also covered. Limitations apply, and has deductibles, copays, or other costs to satisfy.
B	Medicare Part B - Part of the Original Medicare Plan managed by the federal government. This covers medically necessary services from doctors or outpatient hospital care. It also helps with costs associated with some physical and occupational therapist services and some home health care services. A person typically must sign up for Part B and pay a monthly premium in order to benefit from coverage.
C	Medicare Part C - Part of Medicare includes medical and other benefits provided through private health benefits companies (approved by the federal government) known as Medicare Advantage Plans. Plans cover the same or better benefits as the Original Medicare Plan with easy-to-budget copay and coinsurance amounts when a person uses a network doctor and hospital.
D	Medicare Part D - The optional Medicare prescription drug coverage.
X	Medicare Part Unknown - Person is eligible for a Medicare plan but the plan is unidentified
Z	Not Medicare Eligible - Person is not eligible for any Medicare plan.

275 – Medicare Recovery Dispensing Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Field to indicate if days supply on prescription was reduced due to plan limits.	x(1)	A	

Values:

CODE	DESCRIPTION

CODE	DESCRIPTION
Blank	Not Specified
Ø	No reduction applied
1	Days supply reduced due to Client plan limitations
2	Days supply reduced due to Medicare Plan Limits
3	Prescribed Days Supply Dispensed based on Client Approval

276 – Medicare Recovery Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Field to indicate if Medicare was billed in order to recover funds for current or previous claims billed to the client.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø	No Medicare Recovery – No demand for payment has been made by Medicare
1	Prospective Billing – Demand for payment has been made before service provided
2	Retrospective Billing – Demand for payment has been made after service provided

6ØØ-83 - Membership Count Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Further specifies the membership period qualifier in order to calculate the data submitted in the 'Membership Total Count' (6ØØ-88) field.	x(1)	R	

Values:

CODE	DESCRIPTION
1	Beginning of period
2	End of period
3	Average of period
4	Minimum count –lowest number within a given period
5	Maximum count – highest number within a given period
6	Middle of period

6ØØ-86 - Membership Period Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the period of time for which the membership counts cover.	x(1)	R	

Values:

CODE	DESCRIPTION
A	Annually – Once per year

CODE	DESCRIPTION
M	Monthly – Once per month; also12 times per year
Q	Quarterly – Once per quarter of a year or once every three months; also 4 times per year
S	Semi Annually – Once per half of a year or once every six months; also twice per year

6ØØ-89 - Membership Type Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of membership being reported.	x(1)	R	

Values:

CODE	DESCRIPTION
1	Covered Lives - number of lives covered during a period of time
2	Beds - number of beds
3	Retail Stores - A duly-licensed entity that delivers pharmaceutical goods or services for sale to or use by the final consumer.

279 – Member Submitted Claim Program Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
A one-position field indicating the type of member submitted claim program used to process this claim.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Paper Claim Direct - Patient has submitted a paper claim for reimbursement after the pharmacy transmits the claim through an NCPDP Telecommunication claim billing transaction. The patient pays 100%.
2	Paperless Claim Direct – The pharmacy transmits the claim through an NCPDP Telecommunication claim billing transaction and the patient pays 100%. The patient does not need to send in a paper claim as the billing transaction will trigger the reimbursement to the member after a defined period of time.
3	Paper Submit Only – Patient must submit a paper claim as there is no Point of Sale (POS) component.
4	Paper Claim Direct With Dual Pricing - Same as #1 but reimbursement to a patient may differ if no billing transaction (POS claim) was transmitted.
5	Paperless Claim Direct With Dual Pricing – Same as # 2 but reimbursement to the patient may differ if paper claim is received.
6	Paperless Claim Direct With Mail Pricing
7	Paperless Claim Direct and Paper Submit
8	Paper Claim Direct W/ Dual Pricing Determined by Days Supply

943-GQ - Minimum Age Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the minimum age.	x(1)	F	

Values:

CODE	DESCRIPTION
D	Days – Age described in complete units of 24-hour periods
Y	Years – Age described in complete units of 12-month periods

948-GV - Non-Listed Brand Over The Counter Formulary Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Tells the receiver how to treat non-listed branded over the counter drugs.	x(2)	F	

Values:

CODE	DESCRIPTION
See Appendix G. Formulary Status Codes.	

949-GW - Non-Listed Generic Over The Counter Formulary Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Tells the receiver how to treat non-listed generic over the counter drugs.	x(2)	F	

Values:

CODE	DESCRIPTION
See Appendix G. Formulary Status Codes.	

946-GT - Non-Listed Prescription Brand Formulary Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Tells the receiver how to treat non-listed prescription branded drugs.	x (2)	F	

Values:

CODE	DESCRIPTION
See Appendix G. Formulary Status Codes.	

947-GU - Non-Listed Prescription Generic Formulary Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Tells the receiver how to treat non-listed prescription generic drugs.	x (2)	F	

Values:

CODE	DESCRIPTION
See Appendix G. Formulary Status Codes.	

95Ø-GX - Non-Listed Supplies Formulary Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Tells the receiver how to treat non-listed supplies.	x(2)	F	

Values:

CODE	DESCRIPTION
See Appendix G. Formulary Status Codes.	

282 – Non-POS Claim Override Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used for bypassing system edits for non-Point of Sale (non-POS) claims and/or modifying pricing logic.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
H	Bypass all system edits. Pays claims at full amount billed with no copay.
I	Bypasses all system edits. Pays claims at full amount billed with copay applied.
J	Bypasses all system edits. Pays claims according to plan pricing and copay specifications.
K	Pays claims at full amount submitted with copay applied.

415-DF Number of Refills Authorized

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Number of refills authorized by the prescriber.	9(2)	C, D, P, T,A,V	

Values:

CODE	DESCRIPTION
Ø	No refills authorized
1-99	Authorized Refill number - with 99 being as needed, refills unlimited

6Ø1-59 Numerator Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Product is part of numerator and denominator of market share calculation.	x(1)	R	

Values:

CODE	DESCRIPTION
N	No
Y	Yes

453-EJ – Originally Prescribed Product/Service ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the value in 'Originally Prescribed Product/Service Code' (Field 445-EA).	x(2)	T,V	

Values:

CODE	DESCRIPTION
See Section II, Appendix B1 – Product/Service Qualifier	

479-H8 - Other Amount Claimed Submitted Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the additional incurred cost claimed in 'Other Amount Claimed Submitted' (48Ø-H9).	x(2)	T	

Values:

CODE	DESCRIPTION	Value Limitation
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in higher versions.
Ø1	Delivery Cost - An indicator which signifies the amount claimed for the costs related to the delivery of a product or service.	
Ø2	Shipping Cost - The amount claimed for transportation of an item.	
Ø3	Postage Cost - The amount claimed for the mailing of an item.	
Ø4	Administrative Cost - An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance.	
99	Other - Different from those implied or specified	

564-J3 - Other Amount Paid Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code clarifying the value in the 'Other Amount Paid' (565-J4).	x(2)	T,A	

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4. and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
Ø1	Delivery - An indicator which signifies the amount paid for the costs related to the delivery of a product or service.	
Ø2	Shipping - The amount paid for transportation of an item.	
Ø3	Postage - The amount paid for the mailing of an item.	

CODE	DESCRIPTION	Value Limitations
Ø4	Administrative - An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance.	
99	Other	

3Ø8-C8 – Other Coverage Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating whether or not the patient has other insurance coverage.	9(2)	M, P, T, A, R	Used in Manufacturer Rebates Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION	Value Limitations
Ø	Not Specified by patient	
1	No other coverage - Code used in coordination of benefits transactions to convey that no other coverage is available.	
2	Other coverage exists-payment collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received.	
3	Other Coverage Billed – claim not covered - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment denied because the service is not covered.	
4	Other coverage exists-payment not collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received.	
5	Managed care plan denial	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted for use in higher versions of these standards.
6	Other coverage denied-not participating provider	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted for use in higher versions of these standards.
7	Other coverage exists-not in effect on DOS	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted for use in higher versions of these standards.
8	Claim is billing for patient financial responsibility only - Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection or network	

CODE	DESCRIPTION	Value Limitations
	selection.	

342-HC - Other Payer Amount Paid Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Other Payer Amount Paid' (431-DV).	x(2)	T	

Values:

CODE	DESCRIPTION	Value Limitation
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in higher versions.
Ø1	Delivery – An indicator which signifies the amount paid for the costs related to the delivery of a product or service.	
Ø2	Shipping – The amount paid for transportation of an item.	
Ø3	Postage – The amount paid for the mailing of an item.	
Ø4	Administrative – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance.	
Ø5	Incentive-Used to indicate an additional fee or compensation paid to the provider by another payer as an inducement for an action taken by the provider; this might be a collection of survey data or counseling to plan enrollees.	
Ø6	Cognitive Service – Used to indicate pharmacist interaction with patient or caregiver beyond the traditional dispensing/patient instruction activity. For example, therapeutic regimen review, recommendation for additional, fewer, or different therapeutic choices.	
Ø7	Drug Benefit – An indicator which signifies when the dollar amount paid by the other payer has been paid as part of the drug benefit plan.	
Ø8	Sum of All Reimbursements	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in higher versions.
98	Coupon	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in higher versions.
99	Other	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in higher versions.

338-5C - Other Payer Coverage Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the type of 'Other Payer ID' (34Ø-7C).	x(2)	T	

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	
Ø1	Primary – First	
Ø2	Secondary – Second	
Ø3	Tertiary – Third	
Ø4	Quaternary – Fourth	
Ø5	Quinary – Fifth	
Ø6	Senary – Sixth	
Ø7	Septenary - Seventh	
Ø8	Octonary – Eighth	
Ø9	Nonary – Ninth	
98	Coupon	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in higher versions.
99	Other	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in higher versions.

339-6C - Other Payer ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Other Payer ID' (34Ø-7C).	x(2)	T,V	

Values:

CODE	DESCRIPTION	Value Limitation
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in higher versions.
Ø1	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.	Used only in the Prescription Transfer Standard. Not used in any other standard.
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.	Used only in the Prescription Transfer Standard. Not used in any other standard.
Ø2	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.	
Ø3	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.	
Ø4	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.	

CODE	DESCRIPTION	Value Limitation
Ø5	Medicare Carrier Number–A number assigned by the carrier or intermediary which administers the Medicare health insurance program.	
Ø9	Coupon	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in higher versions.
99	Other-Different from those implied or specified.	

143-UW – Other Payer-Patient Relationship Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code assigned by the other payer to indicate the relationship of patient to cardholder.	9(1)	T	Used in Telecommunication Standard Version D.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Cardholder – Patient is the cardholder
2	Spouse – Patient is the husband/wife of the cardholder
3	Child – Patient is a child of the cardholder
4	Other – Relationship to cardholder is not defined in other values

351-NP – Other Payer-Patient Responsibility Amount Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	X(2)	T,A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø1	Amount Applied to Periodic Deductible (517-FH) 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.
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. 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.
Ø4	Amount Exceeding Periodic Benefit Maximum (52Ø-FK) 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.
Ø5	Amount of Copay (518-FI) 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.
Ø6	Patient Pay Amount (5Ø5-F5) as reported by previous payer. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility.
Ø7	Amount of Coinsurance (572-4U) 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,

CODE	DESCRIPTION
	product selection or network selection.
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 reported by previous payer.
12	Amount Attributed to Coverage Gap (137-UP) that was collected from the patient due to a coverage gap.
13	Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.

529-FT – Other Pharmacy Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the pharmacy responsible for the previous event involved in the DUR conflict.	9(1)	T	

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Your Pharmacy - Response code indicating that the pharmacy dispensing the current drug is the same as the pharmacy dispensing the conflicting drug.
2	Other Pharmacy in Same Chain - Code indicating the pharmacy dispensing the drug is in the same chain as the pharmacy dispensing the conflicting drug.
3	Other Pharmacy - Code indicating the pharmacy of the current drug is not the same as the pharmacy of the conflicting drug.

533-FX – Other Prescriber Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code comparing the prescriber of the current prescription to the prescriber of the previously filled conflicting prescription.	9(1)	T	

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Same Prescriber - Response code indicating the prescriber of the current drug is the same as the prescriber of the conflicting drug.
2	Other Prescriber – Code indicating the prescriber of the current drug is not the same as the prescriber of the conflicting drug.

391-MT - Patient Assignment Indicator (Direct Member Reimbursement Indicator)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code to indicate a patient's choice on assignment of benefits.	x(1)	T	Used in Telecommunication Standard Version C.3 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
Y	Patient assigns benefits – Patient has assigned benefits to another party
N	Patient does not assign benefits – Patient has not assigned benefits to another party

3Ø5-C5 Patient Gender Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the gender of the individual.	9(1)	T,A,V	

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Male
2	Female

331-CX - Patient ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Patient ID' (332-CY).	x(2)	T,A,V	

Values:

CODE	DESCRIPTION	Value Limitation
Blank	Not Specified	Used only in Telecommunication Standard Versions C.2 through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
Ø1	Social Security Number – Code indicating that the information to follow is the 9-digit number assigned to an individual by the Social Security Administration for various purposes, including paying and reporting taxes.	
1J	Facility ID Number - ID number assigned by the LTC Facility to the patient	
Ø2	Driver's License Number – Indicator defining the information to follow as the patient's license to operate a motor vehicle	
Ø3	U.S. Military ID – An identification number given to an active or retired member of the US Armed Services or their dependents.	
Ø4	Non-SSN-based patient identifier assigned by health plan – An identification number given to a member by the health plan that is not based on the member's SSN.	
Ø5	SSN-based patient identifier assigned by health plan – An identification number given to a member by the health plan that is based on the member's SSN with modifications so the number is not equal to the SSN.	
Ø6	Medicaid ID-a number assigned by a state Medicaid agency	
99	Other - Different from those implied or specified.	

CODE	DESCRIPTION	Value Limitation
EA	Medical Record Identification Number (EHR) - A unique number assigned to each patient by the provider of service to assist in retrieval of medical records	

3Ø7-C7 - Patient Location

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the location of the patient when receiving pharmacy services.	9(2)	T	Used only in Telecommunication Standard Version 9.Ø and A.1. Field was deleted in Telecommunication Standard Version B.Ø and was replaced in Version B.Ø with *Place of Service 3Ø7-C7*

Values:

CODE	DESCRIPTION
Ø	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
1Ø	Outpatient
11	Hospice
12	End Stage Renal Disease Treatment Facility

3Ø6-C6 - Patient Relationship Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating relationship of patient to cardholder.	9(1)	T,A,V	

Values: For T and A

CODE	DESCRIPTION
Ø	Not Specified
1	Cardholder - The individual that is enrolled in and receives benefits from a health plan
2	Spouse - Patient is the husband/wife/partner of the cardholder
3	Child - Patient is a child of the cardholder
4	Other - Relationship to cardholder is not precise

Values: For V (Note: For transfer of prescriptions on behalf of Healthplans, the acceptable values follow. For Retail Transfer, values in this field will be based upon agreement between trading partners.)

CODE	DESCRIPTION
Ø	Not Specified

CODE	DESCRIPTION
1	Cardholder - The individual that is enrolled in and receives benefits from a health plan
2	Spouse - Patient is the husband/wife/partner of the cardholder
3	Child - Patient is a child of the cardholder
4	Other - Relationship to cardholder is not precise
5	Student - A dependent child enrolled in school
6	Disabled Dependent - A dependent, regardless of age, who is disabled
7	Adult Dependent - A dependent determined to be an adult. Parents fall under this category
8	Significant Other - Partner other than the spouse

384-4X - Patient Residence

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the patient's place of residence.	9(2)	T,V,A	Used in Telecommunication Standard Version B.Ø or greater but not in lower versions. Used in Post Adjudication Standard Version 2.Ø or greater but not in lower version.

Values:

CODE	DESCRIPTION
Ø	Not Specified=Other patient residence not identified below.
1	Home= Location, other than a hospital or other facility, where the patient receives drugs or services in a private residence.
2	Skilled Nursing Facility=A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative service but does not provide the level of care or treatment available in a hospital.
3	Nursing Facility= A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis,, health-related care services above the level of custodial care to other than mentally retarded individuals.
4	Assisted Living Facility= Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
5	Custodial Care Facility=A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
6	Group Home=Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.
7	Inpatient Psychiatric Facility=A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
8	Psychiatric Facility – Partial Hospitalization=A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
9	Intermediate Care Facility/Mentally Retarded=A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
1Ø	Residential Substance Abuse Treatment Facility=A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory

CODE	DESCRIPTION
	tests, drugs and supplies, psychological testing, and room and board.
11	Hospice= A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
12	Psychiatric Residential Treatment Facility=A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
13	Comprehensive Inpatient Rehabilitation Facility=A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
14	Homeless Shelter=A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
15	Correctional Institution=A facility that provides treatment and rehabilitation of offenders through a program of penal custody.

324-CO - Patient State/Province Address

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Standard State/Province code as defined by appropriate government agency.	x(2)	T	

Values:

CODE	DESCRIPTION
See Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

568-J7 - Payer ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the type of payer ID	x(2)	T,V	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø1	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.
Ø2	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.
Ø3	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.
Ø4	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.
99	Other- Different from those implied or specified.

288 – Payroll Class

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
A field defined by the client indicating the payroll class of the member.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Hourly
2	Salary

118-TS – Pay To Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Pay To ID' (119-TT).	X(2)	T	Used in Telecommunication Standard Version D.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
ØØ	Not Specified
Ø1	National Provider Identifier (NPI) = a standard unique health identifier for health care providers. The NPI is a 1Ø position numeric identifier with a check digit in the 1Øth position and is assigned by the National Provider System (NPS).
11	Federal Tax ID = a 9-digit number assigned by the Internal Revenue Service to sole proprietors, corporations, partnerships, estates, trusts, and other entities for the purpose of tax filing and reporting.

123-TX – Pay To State/Province Address

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Standard state /province code as defined by appropriate government agency.	X(2)	T	Used in Telecommunication Standard Version D.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

561-AZ – Percentage Sales Tax Basis Paid

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the percentage sales tax paid basis.	x(2)	T,A	

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	
Ø1	Gross Amount Due	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used

CODE	DESCRIPTION	Value Limitations
		in higher versions.
Ø2	Ingredient Cost - The dollar amount/value of the prescription submitted by the pharmacist. Does not include sales tax or dispensing fee.	
Ø3	Ingredient Cost + Dispensing Fee - The dollar amount/value of the prescription submitted by the pharmacist plus dispensing fee.	

484-JE – Percentage Sales Tax Basis Submitted

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the basis for percentage sales tax.	x(2)	T	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø2	Ingredient Cost - The dollar amount/value of the prescription submitted by the pharmacist. Does not include sales tax or dispensing fee.
Ø3	Ingredient Cost + Dispensing Fee - The dollar amount/value of the prescription submitted by the pharmacist plus dispensing fee.

6Ø1-99 - Performance Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The type of performance on which the rebate amount is based.	x(3)	R	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Field was deleted in Manufacturer Rebates Standard Version Ø4.Ø1.

Values:

CODE	DESCRIPTION
CR	Compliance
CS	Contract Sales
CYC	Cycles
DOT	Days of Therapy
GPP	Growth Period-to-Period
MDT	Market Share Percent based on Therapy
MSD	Market Share Percent based on Dollars
MSR	Market Share Percent based on Scripts
MSQ	Market Share Percent based on Quantity
MSU	Market Share Percent based on Units
VL	Vials
VS	Volume Scripts
VU	Volume Units
Z__	Mutually Agreed Upon Performance Qualifier (All codes beginning with the letter Z are reserved for use between trading partners.)

15Ø – Pharmacy Class Code Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Pharmacy Class Code' (289).	x(1)	A	Used in Post Adjudication Standard Version 2.Ø or greater but not in lower version

Values:

CODE	DESCRIPTION
Blank	Not Used
1	Processor-defined - The processor supports and maintains their own codes.
2	Pharmacy Dispenser Type from NCPDP Pharmacy Database (licensees only) - The values are from the NCPDP Pharmacy Database.
3	Other

146 – Pharmacy Dispenser Type Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Pharmacy Dispenser Type' (29Ø).	x(1)	A	Used in Post Adjudication Standard Version 2.Ø or greater but not in lower version

Values:

CODE	DESCRIPTION
Blank	Not Used
1	Processor-defined - The processor supports and maintains their own codes.
2	Pharmacy Dispenser Type from NCPDP Pharmacy Database (licensees only) - The values are from the NCPDP Pharmacy Database.
3	Other

6Ø1-46 - Pharmacy ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of data being submitted in the 'Pharmacy ID Code' (6Ø1-45) field.	x(1)	R	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Field was deleted in Manufacturer Rebates Standard Version Ø4.Ø1.

Values:

CODE	DESCRIPTION
C	Contracting organization (PMO) assigned ID number
D	DEA number
F	Federal Tax ID Number
H	HIBCC HIN
M	Manufacturer (PICO) assigned ID number
N	NCPDP Provider Identification Number
P	National Provider ID (NPI)
T	Telephone number
Z	Mutually agreed upon ID number

832-6F - Pharmacy Location State

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
State abbreviation of pharmacy.	x(2)	C,D	

Values:

CODE	DESCRIPTION
See Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

147-U7 – Pharmacy Service Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy, or when benefits are based upon the type of service performed.	9(2)	T,R	Used in Telecommunication Standard Version D.Ø or greater but not in lower versions. Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
1	**Community/Retail Pharmacy Services**. Storing, preparing, and dispensing medicinal preparations and/or prescriptions for a local patient population in accordance with federal and state law; counseling patients and caregivers (sometimes independent of the dispensing process); administering vaccinations; and providing other professional services associated with pharmaceutical care such as health screenings, consultative services with other health care providers, collaborative practice, disease state management, and education classes.
2	**Compounding Pharmacy Services.** Preparation, mixing, assembling, packaging and labeling of a drug or device that result in a customized medication prepared by a pharmacist according to a practitioner's specifications to meet an individual patient need. Medications are typically made using raw chemicals, powders and specialized equipment.
3	**Home Infusion Therapy Provider Services.** Decentralized patient care services performed with expertise in USP 797-compliant sterile drug compounding that provides care to patients with acute or chronic conditions generally pertaining to parenteral administration of drugs, biologics and nutritional formulae administered through catheters and/or needles in home and alternate sites. Extensive professional pharmacy services, care coordination, infusion nursing services, supplies and equipment are provided to optimize efficacy and compliance.
4	**Institutional Pharmacy Services.** Compounding and delivery of medicinal preparations to be administered to the patient by nursing or other authorized personnel in a hospital (inpatient) or institution.
5	**Long Term Care Pharmacy Services.** Dispensing medicinal preparations delivered to patients residing within an intermediate or skilled nursing facility, including intermediate care facilities for the mentally retarded, hospice, assisted living facilities, group homes, and other forms of congregate living arrangements.
6	**Mail Order Pharmacy Services.** Compounding or dispensing prescriptions or other medications in accordance with federal and state law, using common carriers to deliver the medications to patient or their caregivers. Consultation to patients and caregivers (sometimes independent of the dispensing process) through telephone or email contact and provide other professional services associated with pharmaceutical care appropriate to the setting.
7	**Managed Care Organization Pharmacy Services.** Compounding and dispensing of medicinal preparations by a pharmacy owned by a managed care organization (MCO) to the MCO's covered members.
8	**Specialty Care Pharmacy Services.** Preparation and dispensing of high cost medicinal preparations to patients who are undergoing intensive therapies for illnesses that are generally chronic, complex and potentially life threatening. Often these therapies require specialized delivery and administration.
99	**Other**. Different from that or those implied or specified.

955–HR - Pharmacy Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Type of Pharmacy.	x(1)	F	

Values:

CODE	DESCRIPTION
R	Retail – A dully-licensed entity that delivers pharmaceutical goods or services for sale to or use by the final consumer.
M	Mail Order –A distribution center that provides medications directly to patients via US Mail or other delivery services.
S	Specialty – A pharmacy which typically dispenses exclusively those medications which require special handling due to their storage or handling requirements.
L	Long-Term Care-LTC is a community network of health and supportive services that help individuals and their caregivers manage health needs, personal needs and activities of daily living in a variety of settings on a long-term basis. The various components in the LTC spectrum include nursing homes, skilled nursing facilities, housing with supportive services, assisted living, continuing care retirement communities, adult day care, intermediate care facilities for the mentally retarded and developmentally disabled, home health care, hospice care and respite care.
A	Any – Code indicating a pharmacy without restriction or exception

3Ø7-C7 – Place of Service

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the place where a drug or service is dispensed or administered.	9(2)	T,A	Used in Telecommunication Standard Version B.Ø or greater but not in lower versions. Used in Post Adjudication Standard Version 2.Ø or greater but not in lower version.

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used in Telecommunication Standard Version B.Ø through C.4. Value was deleted for use in higher versions of this standard.
1	Pharmacy= A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.	
2	Unassigned	
3	School= A facility whose primary purpose is education.	
4	Homeless Shelter=A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).	
5	Indian Health Service Free-standing Facility=A facility or location owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.	
6	Indian Health Service Provider-based Facility=A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.	
7	Tribal 638 Free-standing Facility=A facility or location owned and operated by a	

CODE	DESCRIPTION	Value Limitations
	federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation service to tribal members who do not require hospitalization.	
8	Tribal 638 Provider-based Facility=A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.	
9-1Ø	Unassigned	
11	Office=Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.	
12	Home=Location, other than a hospital or other facility, where the patient receives care in a private residence.	
13	Assisted Living Facility=Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.	
14	Group Home=Congregate residential foster care setting for children and adolescents in state custody that provides some social , health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.	
15	Mobile Unit=A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.	
16	Temporary Lodging=A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.	
17-19	Unassigned	
2Ø	Urgent Care Facility=Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	
21	Inpatient Hospital=A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.	
22	Outpatient Hospital=A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.	
23	Emergency Room=Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	
24	Ambulatory Surgical Center=A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.	
25	Birthing Center=A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of new born infants.	
26	Military Treatment Facility=A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).	
27-3Ø	Unassigned	

CODE	DESCRIPTION	Value Limitations
31	Skilled Nursing Facility=A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.	
32	Nursing Facility=A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.	
33	Custodial Care Facility=A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.	
34	Hospice=A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.	
35-4Ø	Unassigned	
41	Ambulance-Land=Land A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	
42	Ambulance-Air or Water=An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	
43-48	Unassigned	
49	Independent Clinic=A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.	
5Ø	Federally Qualified Health Center=A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.	
51	Inpatient Psychiatric Facility=A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	
52	Psychiatric Facility – Partial Hospitalization=A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.	
53	Community Mental Health Center=A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.	
54	Intermediate Care Facility/Mentally Retarded=A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.	
55	Residential Substance Abuse Treatment Facility=A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.	
56	Psychiatric Residential Treatment Center=A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.	

CODE	DESCRIPTION	Value Limitations
57	Non-residential Substance Abuse Treatment=A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and Facility * counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.	
58-59	Unassigned	
6Ø	Mass Immunization Center=A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.	
61	Comprehensive Inpatient Rehabilitation Facility=A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.	
62	Comprehensive Outpatient Rehabilitation Facility=A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.	
63-64	Unassigned	
65	End-State Renal Disease=A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.	
66-7Ø	Unassigned	
71	Public Health Clinic=A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.	
72	Rural Health Clinic=A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.	
73-8Ø	Unassigned	
81	Independent Laboratory=A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	
82-98	Unassigned	
99	Other Place of Service=Other place of service not identified above.	

6ØØ-92 - Plan Affiliation Parent Plan ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of data being submitted in the 'Plan Affiliation Parent Plan ID' (6ØØ-91) field.	x(1)	R	

Values:

CODE	DESCRIPTION
C	Contracting organization (PMO) assigned ID number - Alphanumeric code used to identify the PMO that sent a NCPDP manufacturer rebate flat file standard layout to a PICO. This code is an internal number assigned by the PMO.
D	DEA number- The number assigned by the DEA to all businesses that manufacturer or distribute controlled pharmaceuticals, all health professionals who dispense, administer, or prescribe controlled pharmaceuticals an all pharmacies that fill prescriptions.
F	Federal Tax ID Number — A 9-digit number assigned by the Internal Revenue Service to sole

CODE	DESCRIPTION
	proprietors, corporations, partnerships, estates, trusts, and other entities for the purpose of tax filing and reporting.
H	HIBCC 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.
M	Manufacturer (PICO) assigned ID number- A value assigned by a manufacturer and used internally to identify a given trading partner.
P	National Provider ID (NPI) –A HIPAA-mandated standard unique health identifier for health care providers
T	Telephone number - Code indicating that the information to follow is a telephone number (for voice, data, fax, etc.).
Z	Mutually agreed upon ID number - A value mutually agreed upon by trading partners to identify a given data element. The value may be unique between the trading partners or from an existing industry standard.

292 - Plan Cutback Reason Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the type of cutback, if any, imposed by plan.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Medicare Part B (Plan Cutback) - A reduction in a quantity of a medical service covered by Medicare Part B
2	Medicare Part B with days supply cutback - A reduction in the days supply of a service/drug covered by Medicare Part B
C	Net Check limit cutback - A reduction in the net amount of a check
D	Days Supply cutback – A reduction in the days supply
I	Ingredient Cost cutback - A reduction in the ingredient cost
Q	Quantity cutback - A reduction in the quantity

6ØØ-93 - Plan Degree Managed

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the level of formulary management.	x(4)	R	

Values:

CODE	DESCRIPTION
1Ø1Ø	Claims Processing-The term used to describe the entire procedure related to the processing of pharmacy claims. It includes logging in the claim data entry of the line items, audit of the unit utilization, recording of disputes (if any) and processing the check.
2Ø1Ø	Formulary Management-The process used to manage pharmacy utilization by means of interventions impacting providers, patients and pharmacists.
3Ø1Ø	Disease Management-Work in partnership with managed care, providing information on the therapeutic value and cost- effectiveness of treatments, developing measures, outcomes, supporting protocol development and patient tracking, improving compliance and education.
4Ø1Ø	Intervention- Prospective and retrospective means to manage pharmaceutical utilization. Prospective

CODE	DESCRIPTION
	interventions include: concurrent DUR programs, messaging to providers at point-of-sale, and prior authorization. Retrospective interventions include DUR programs.
99Ø1	Other- Any other degree managed types not covered by definitions above. New codes, definitions and descriptions should be developed for anything classified as "Other".
9999	Not Classified

6ØØ-95 - Plan ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of data being submitted in the 'Plan ID Code' (6ØØ-94) field.	x(1)	R	

Values:

CODE	DESCRIPTION
C	Contracting organization (PMO) assigned ID number - Alphanumeric code used to identify the PMO that sent a NCPDP manufacturer rebate flat file standard layout to a PICO. This code is an internal number assigned by the PMO.
D	DEA number - The number assigned by the DEA to all businesses that manufacturer or distribute controlled pharmaceuticals, all health professionals who dispense, administer, or prescribe controlled pharmaceuticals an all pharmacies that fill prescriptions.
F	Federal Tax ID Number - A 9-digit number assigned by the Internal Revenue Service to sole proprietors, corporations, partnerships, estates, trusts, and other entities for the purpose of tax filing and reporting.
H	HIBCC 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.
M	Manufacturer (PICO) assigned ID number - A value assigned by a manufacturer and used internally to identify a given trading partner.
P	National Provider ID (NPI) – A HIPAA-mandated standard unique health identifier for health care providers
T	Telephone number - Code indicating that the information to follow is a telephone number (for voice, data, fax, etc.).
Z	Mutually agreed upon ID number - A value mutually agreed upon by trading partners to identify a given data element. The value may be unique between the trading partners or from an existing industry standard.

6Ø1-Ø1 - Plan Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of plan.	x(4)	R.A	

Values:

CODE	DESCRIPTION
1ØØØ	ALTERNATE SITE INFUSION=An independent facility that provides infusion care.
111Ø	BLUES PLAN=A plan that contracts with Blue Cross Blue Shield for their health care benefits.
112Ø	BLUES HMO=An HMO plan that contracts with Blue Cross Blue Shield for their health care benefits.
113Ø	BLUES SELF INSURED EMPLOYER GROUPS=An Employer Group that contracts with Blue Cross Blue Shield for their health care benefits.
114Ø	BLUES PPO=A PPO plan that contracts with Blue Cross Blue Shield for their health care benefits.

CODE	DESCRIPTION
121Ø	CLAIMS PROCESSOR=A plan in which the Managed Care Provider provides pharmacy claims processing services only, not formulary management services.
122Ø	CHAIN=A chain pharmacy.
123Ø	CLINIC=A medical clinic in which physicians provide health care services.
131Ø	EMPLOYER GROUP=A health plan where the risk for medical cost is assumed by the company rather than an insurance company or PMO.
132Ø	UNION EMPLOYEES GROUP=A health plan where the risk for medical cost of the union employees is assumed by the company rather than an insurance company or PMO.
133Ø	SALARIED EMPLOYEE GROUP=A health plan where the risk for medical cost of the salaried employees is assumed by the company rather than an insurance company or PMO.
134Ø	HOURLY EMPLOYEES GROUP=A health plan where the risk for medical cost of the hourly employees is assumed by the company rather than an insurance company or PMO.
135Ø	RETIRED EMPLOYEES GROUP=A health plan where the risk for medical cost of the retired employees is assumed by the company rather than an insurance company or PMO.
151Ø	FAMILY PLAN=A health plan that augments the cardholders plan to include dependents.
152Ø	HOME HEALTH=Private or public agency that offers nursing, dietary, social, therapy and counseling services in the home of the patient.
153Ø	HOSPITAL=Plan in which health care is provided to hospital agency.
16ØØ	HMO=A general classification of HMO plans; could be Group, IPA, Network, and/or Staff, etc.
161Ø	HMO GROUP=An HMO that contracts with one or more physician groups. The medical group is usually paid with a capitation fee.
162Ø	HMO IPA=A type of HMO that contracts with individual physicians to provide services to the HMO's enrollees. Doctors maintain their own private practices and thus can contract with other HMOs or see regular fee-for-service patients as well.
163Ø	HMO NETWORK=An HMO that is a combination of Staff, IPA, and Group Model HMOs. The most typical arrangement is a combination of individual physicians in private practice and medical groups, with the predominant organization around medical groups.
164Ø	HMO STAFF=An HMO in which health services are provided by physicians who are salaried employees of the HMO and who work in a building that is owned by the HMO. These physicians see only members of the HMO and have no private fee-for-service practices.
165Ø	HMO COMBO/MIXED=An HMO that is a combination of Staff, IPA, and Group Model HMOs.
171Ø	INDEMNITY INSURER=A health insurance plan in which the insured person pays for health care services out-of-pocket and is later reimbursed for covered expenses.
172Ø	INTEGRATED CARVE OUT=A plan that integrates different providers for varying services (i.e., psychiatric services, Medicaid, etc.).
181Ø	LONG TERM CARE PROVIDER=A pharmacy that provides long-term care coverage.
182Ø	LONG TERM CARE FACILITY=A nursing home, hospice, or other institution that provides long-term care.
191Ø	GOVERNMENT=Combination of Medicaid and Medicare.
192Ø	MEDICAID=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.
193Ø	MEDICARE=The federal program providing health insurance for people aged 65 and older and for disabled people of all ages.
2Ø1Ø	MAIL ORDER=A plan which receives pharmacy benefit services through the mail only. The plan type can vary.
2Ø2Ø	NURSING HOME=A long-term care facility normally for the elderly.
211Ø	PHARMACY BENEFIT MANAGER (PBM)=An organization where pharmaceutical decisions are not left entirely to the physician. It attempts to control health care costs of member plans by instituting a variety of cost containment strategies such as drug formularies.
22ØØ	PPO=A general classification of PPO plans; could be Full Service, General Medical/Surgical and/or Specialty, etc.
221Ø	PPO FULL SERVICE=An arrangement under which an insurance company or employer negotiates discounted fees for all services with networks of health care providers in return for guaranteeing a certain volume of patients.

CODE	DESCRIPTION
222Ø	PPO GENERAL MEDICAL/SURGICAL=An arrangement under which an insurance company or employer negotiates discounted fees for general medical and surgical services with networks of health care providers in return for guaranteeing a certain volume of patients.
223Ø	PPO SPECIALTY=An arrangement under which an insurance company or employer negotiates discounted fees for specialty services with networks of health care providers in return for guaranteeing a certain volume of patients.
224Ø	PPO WORKERS COMP=An arrangement under which an insurance company or employer negotiates discounted fees for workers compensation services with networks of health care providers in return for guaranteeing a certain volume of patients.
231Ø	PREFERRED PHARMACY PROVIDERS FOR MANAGED CASH PRESCRIPTIONS= A health insurance plan in which the insured person receives discounted prescriptions and pays for health care services out-of-pocket. These plans do utilize a formulary.
241Ø	STATE GOVERNMENT-SELF INSURED EMPLOYER GROUP=A health plan where the risk for medical cost is assumed by the state government rather than an insurance company or managed care plan.
25ØØ	THIRD PARTY ADMINISTRATOR (TPA)=An individual or company that contracts with employers who want to self-insure the health of their employees. They develop and coordinate self-insurance programs, process and pay the claims and may help locate stop-loss insurance for the employer.
251Ø	TPA PBM-MANAGED=A TPA organization whose formulary is managed by the contracted PBM.
252Ø	TPA SELF-MANAGED=A TPA organization whose formulary is self-managed.
261Ø	WORKERS COMPENSATION=Plan providing workers compensation insurance (insurance required by law from employers for the protection of employees while engaged in the employer's business).
99Ø1	OTHER=Any other plan types not covered by definitions above. New codes, definitions and descriptions should be developed for anything classified as "Other".
9999	NOT CLASSIFIED=Managed Care Organization chooses not to classify the plan.

6Ø1-Ø2 - Plan Type Service

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the type of service for the plan.	x(4)	R	

Values:

CODE	DESCRIPTION
1Ø1Ø	Mail Order- The process by which prescriptions are dispensed via the mail. An organization in business to provide mail order prescription drug benefits to clients.
1Ø2Ø	Internal Mail Order-A PMO-owned and operated organization in business to provide mail order prescription drug benefits to clients.
1Ø3Ø	External Mail Order-A non-PMO-owned and operated organization in business to provide mail order prescription drug benefits to clients.
2Ø1Ø	Cash Retail-Payments made by patients to a drug dispenser (retail pharmacy) where the patient pays the full cost of the prescription at point-of-sale.
3Ø1Ø	Managed Retail-Payments made by contracted insurer to drug dispenser (retail pharmacy) where the patient may pay a co-payment toward the cost of the prescription. The contracted insurer may selectively choose to pay for only certain pre-identified drugs.
4Ø1Ø	Combination-Combination of mail and retail; patient has ability to purchase drug through both facilities.
4Ø2Ø	Combination Internal Mail Order-A combination of mail and retail where the patient has the ability to purchase drug through both a retail facility and a PMO-owned and operated mail order service provider.
4Ø3Ø	Combination External Mail Order-A combination of mail and retail where the patient has the ability to purchase drug through both a retail facility and a non-PMO-owned and operated mail order service provider.
99Ø1	Other-Any other service types not covered by definitions above. New codes, definitions and descriptions should be developed for anything classified as "Other".
9999	Not Classified

956-HS - Preference Level

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
If there are multiple alternatives for a given Source drug, this is the payer's order of preference (a higher number equals greater preference).	9(2)	F	

Values:

CODE	DESCRIPTION
99	Most preferred
98-2	Ordered preference between most to least
1	Least preferred

552-AP – Preferred Product ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the type of product ID submitted in 'Preferred Product ID' (553-AR).	x(2)	T	

Values:

CODE	DESCRIPTION
See Section II, Appendix B1– Product/Service Qualifier	

335-2C Pregnancy Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the patient as pregnant or non-pregnant.	x(1)	M, T,V	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Not pregnant
2	Pregnant

295 – Prescriber Certification Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates a provider's certification in the health plan program.	x(2)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Active - Prescriber has been certified as a participant
2	Retired (Inactive) - Prescriber that is no longer working.
3	Voluntary Inactive - Prescriber that has given up their certification

CODE	DESCRIPTION
4	Deceased - Prescriber that has died
5	Pending health plan approval - Prescriber has applied for certification and is awaiting finalization of approval process
6	License Revoked - Prescriber has had his license taken away
7	Utilization Review Sanctioned – Prescriber has been sanctioned due to prescribing habits
8	Fraud Conviction (Inactive) - Prescriber has been convicted by the courts of fraud
9	Administration Action (Inactive) - Prescriber's license has been deactivated for administrative purposes
1Ø	Terminated - Prescriber's certification/license has been terminated
11	Decertified - Prescriber's certification has been removed
12	Reopened after Sanction or Decertification - Prescriber's certification process is reopened for review after having been revoked
13	Federal Sanction - Provider has been restricted by a federal certifying entity.
14	Out of Network: Participating
15	Out of Network: Non-Participating
16	In Network: Participating – prescriber is a contracted plan physician
17	In Network: Non-Participating – prescriber is not a contracted plan physician

466-EZ - Prescriber ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Prescriber ID' (411-DB).	x(2)	T, M, A, R,V	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values: (For Standards '*T', 'M', 'A*')

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted for use in higher versions of these standards.
Ø1	National Provider Identifier (NPI) = a standard unique health identifier for health care providers. The NPI is a 1Ø position numeric identifier with a check digit in the 1Øth position and is assigned by the National Provider System (NPS).	
Ø2	Blue Cross = a number assigned by a Blue Cross health plan which is a nonprofit hospital expense prepayment plan primarily designed to provide benefits for hospitalization coverage, with certain restrictions on the accommodations to be used.	
Ø3	Blue Shield = a number assigned by a Blue Shield health plan which is a prepayment plan offered by voluntary nonprofit organizations that cover medical and surgical expenses.	
Ø4	Medicare = a number assigned by the carrier or intermediary which administers the Medicare health insurance program for people age 65 or older, some people with disabilities under age 65, and people with end-stage renal disease. Medicare has two parts, hospital insurance (Part A) and medical insurance (Part B).	
Ø5	Medicaid = a number assigned to a provider by a state Medicaid agency. Each state has a unique identifier. Medicaid is a program established pursuant to Title XIX of the Social Security Act to provide	

CODE	DESCRIPTION	Value Limitations
	medical benefits for certain categories of low-income individuals. The program provides benefits to indigent and disabled individuals and members of families receiving Aid to Families with Dependent Children. States have the option to provide benefits to a broader range of individuals. The program is a cooperative arrangement between the federal government and the states, under which both the federal government and a participating state contribute financial support. The state, however, retains a considerable amount of discretion over the operation and administration of the program, and has the right to determine the benefits to be provided, rules for eligibility, rates of payment for services and other matters, as long as broad regulatory guidelines established by the federal government are followed.	
Ø6	UPIN (Unique Physician/Practitioner Identification Number) = a number assigned to each Medicare physician/practitioner to identify the referring or ordering physician on Medicare claims. UPINs consist of an alpha character and five numerics and is assigned by CMS.	
Ø7	NCPDP Provider Identification Number (National Council for Prescription Drug Programs Provider Identification Number)	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted for use in higher versions of these standards.
Ø8	State License = the number assigned and required by a State Board or other State regulatory agency that uniquely identifies a pharmacy by category, as defined by each State or Territory or a prescriber by practice specialty for which they reside/practice.	
Ø9	CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) = a number that uniquely identifies a provider that participates in the CHAMPUS program which is a federal medical benefits program that helps pay for civilian medical care rendered to the spouses and children of active duty and retired personnel.	
1Ø	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.	
11	Federal Tax ID = a 9-digit number assigned by the Internal Revenue Service to sole proprietors, corporations, partnerships, estates, trusts, and other entities for the purpose of tax filing and reporting.	
12	Drug Enforcement Administration (DEA) Number = the number assigned by the DEA to all businesses that manufacture or distribute controlled pharmaceuticals, all health professionals who dispense, administer, or prescribe controlled pharmaceuticals and all pharmacies that fill prescriptions.	
13	State Issued = a unique number issued by a state program or organization other than Medicaid, to a provider of service.	
14	Plan Specific = a unique proprietary number assigned by a commercial health care plan to a provider of service.	
15	HCID (HC IDea) = A 1Ø-character, alphanumeric identifier assigned by NCPDP to identify authorized prescribers of drugs.	
99	Other = used to identify other health plans and enumerating organizations not listed above.	

Values: For '*R*'

CODE	DESCRIPTION
A	AMA or Medical Education (ME) number - A unique identification number assigned by the AMA to each physician or medical student when he or she is added to the AMA Physician Masterfile. The ME number is a record locator and is not related in any way to a medical license or other certification. (value for 'R')

CODE	DESCRIPTION
B	AOA Doctor of Osteopathy (DO) number - number assigned to each DO physician and is used in a variety of manners by the physician. (value for 'R')
C	Contracting Organization PMO number - Alphanumeric code used to identify the PMO that sent a NCPDP manufacturer rebate flat file standard layout to a PICO. This code is an internal number assigned by the PMO.
D	DEA number The identifier assigned by the DEA to all businesses that manufacturer or distribute controlled pharmaceuticals, all health professionals who are permitted to dispense, administer, or prescribe controlled pharmaceuticals and all pharmacies that fill prescriptions.
H	HIBCC 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.
M	Manufacturer (PICO) assigned number - A value assigned by a manufacturer and used internally to identify a given trading partner.
P	National Provider ID - A HIPAA-mandated standard unique health identifier for health care providers
T	Telephone number - Code indicating that the information to follow is a telephone number (for voice, data, fax, etc.).
Z	Mutually agreed upon ID number - A value mutually agreed upon by trading partners. The value may be unique between the trading partners or from an existing industry standard.

621-RY – Prescriber Specialty

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Specialty of prescriber.	x(3)	V	

Values:

CODE	DESCRIPTION
See Section II - APPENDIX J – VALUES FOR SPECIALTY CODES	

367-2N – Prescriber State/ Province Address

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Standard state/province code as defined by appropriate government agency.	x(2)	T	Used in Telecommunication Standard Version C.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

296 Prescriber Taxonomy Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The taxonomy is defined as a classification scheme that codifies provider type and provider area of specialization.	x(1Ø)	A	

Values:

CODE	DESCRIPTION
The values can be obtained from the following link: http://www.wpc-edi.com/codes/taxonomy	

419-DJ – Prescription Origin Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the origin of the prescription.	9(1)	T, P, A	

Values:

CODE	DESCRIPTION
Ø	Not Known
1	Written - Prescription obtained via paper.
2	Telephone - Prescription obtained via oral instructions or interactive voice response using a phone.
3	Electronic - Prescription obtained via electrical, digital, magnetic, wireless, optical, electromagnetic or similar capabilities that are computer-to-computer.
4	Facsimile - Prescription obtained via transmission using a fax machine.

297 – Prescription Over The Counter Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The indicator that specifies this prescription is a federal/legend (RX prescription only) or non-prescription drug (OTC).	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
O	Over the counter (OTC) – prescription not required to be dispensed
F	Federal/Legend (Rx Prescription Only)

455-EM Prescription/Service Reference Number Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the type of billing submitted.	x(1)	C,D,P,R,T,A	

Values: For C, D, P, T, A

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
1	Rx Billing - Transaction is a billing for a prescription or OTC drug product	
2	Service Billing - Transaction is a billing for a professional service performed.	

Values: For R

CODE	DESCRIPTION
1	Telecommunication v 5.1-6.Ø Rx- 7 bytes
2	Telecommunication v 7.Ø–C.4 Rx- 9 bytes
3	Telecommunication v DØ or higher Rx-12 bytes
Z	Trading Partner Defined – Mutually agreed upon

6Ø1-49 Prescription Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the prescription as either a new/refill, an adjusted prescription or a reversal.	9(1)*b* or 9(1)-	R	

Values:

CODE	DESCRIPTION
1*b*	New/Refill
Øb	Adjustment – a modification to a previously submitted prescription
1	Reversal – a cancellation to a previously submitted prescription

468-2E – Primary Care Provider ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Primary Care Provider ID' (421-DL).	x(2)	T, M, A	

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
Ø1	National Provider Identifier (NPI) = a standard unique health identifier for health care providers. The NPI is a 1Ø position numeric identifier with a check digit in the 1Øth position and is assigned by the National Provider System (NPS).	
Ø2	Blue Cross = a number assigned by a Blue Cross health plan which is a nonprofit hospital expense prepayment plan primarily designed to provide benefits for hospitalization coverage, with certain restrictions on the accommodations to be used.	
Ø3	Blue Shield = a number assigned by a Blue Shield health plan which is a prepayment plan offered by voluntary nonprofit organizations that cover medical and surgical expenses.	
Ø4	Medicare = a number assigned by the carrier or intermediary which administers the Medicare health insurance program for people age 65 or older, some people with disabilities under age 65, and people with end-stage renal disease. Medicare has two parts, hospital insurance (Part A) and medical insurance (Part B).	
Ø5	Medicaid = a number assigned to a provider by a state Medicaid agency. Each state has a unique identifier. Medicaid is a program established pursuant to Title XIX of the Social Security Act to provide medical benefits for certain categories of low-income individuals. The program provides benefits to indigent and disabled individuals and members of families receiving Aid to Families with Dependent Children. States have the option to provide benefits to a broader range of individuals. The program is a cooperative arrangement between the federal government and the states, under which both the federal government and a participating state contribute financial support. The state, however, retains a considerable amount of discretion over the operation and administration of the program, and has the right to determine the benefits to be provided, rules for eligibility, rates of payment for services and other matters, as long as broad regulatory guidelines established by the federal government are followed.	
Ø6	UPIN (Unique Physician/Practitioner Identification Number) = a number assigned to each Medicare physician/practitioner to identify the referring or ordering physician on Medicare claims. UPINs consist of an alpha character and five numerics and is	

CODE	DESCRIPTION	Value Limitations
	assigned by CMS.	
Ø7	NCPDP Provider Identification Number (National Council for Prescription Drug Programs Provider Identification Number)	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
Ø8	State License = the number assigned and required by a State Board or other State regulatory agency that uniquely identifies a pharmacy by category, as defined by each State or Territory or a prescriber by practice specialty for which they reside/practice.	
Ø9	CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) = a number that uniquely identifies a provider that participates in the CHAMPUS program which is a federal medical benefits program that helps pay for civilian medical care rendered to the spouses and children of active duty and retired personnel.	
1Ø	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.	
11	Federal Tax ID = a 9-digit number assigned by the Internal Revenue Service to sole proprietors, corporations, partnerships, estates, trusts, and other entities for the purpose of tax filing and reporting.	
12	Drug Enforcement Administration (DEA) Number = the number assigned by the DEA to all businesses that manufacture or distribute controlled pharmaceuticals, all health professionals who dispense, administer, or prescribe controlled pharmaceuticals and all pharmacies that fill prescriptions.	
13	State Issued = a unique number issued by a state program or organization other than Medicaid, to a provider of service.	
14	Plan Specific = a unique proprietary number assigned by a commercial health care plan to a provider of service.	
15	HCID (HC IDea) = A 1Ø-character, alphanumeric identifier assigned by NCPDP to identify authorized prescribers of drugs	
99	Other = used to identify other health plans and enumerating organizations not listed above.	

663-V2 - Prior Authorization Applicability

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
This field conveys if a question must always be answered, or if the answer is conditional based on the answer to another question.	x(1)	F	Used in Formulary and Benefit Standard Version 2.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
A	Always applicable
C	Conditionally applicable

668-V7 - Prior Authorization Comparison Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
A code that conveys the relationship between the answered value to a Prior	x(2)	F	Used in Formulary and Benefit Standard Version 2.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
=	Equal to
<	Less Than
>	Greater Than
≠ or != or <>	Not Equal To
≤ or <=	Less Than or Equal To
≥ or >=	Greater Than or Equal To

66Ø-T8 - Prior Authorization Question Code Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
This field specifies which coding system is being used. Used in combination with Question Code to uniquely identify each Prior Authorization question on a form.	x(16)	F	Used in Formulary and Benefit Standard Version 2.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
LOINC	A standard question code defined in the Logical Observation Identifier Names and Codes database. (All LOINC codes and descriptions are copyrighted by the Regenstrief Institute, with all rights reserved. See http://www.LOINC.org)
Payer	A non-standard, payer specific question code defined by the Prior Authorization form originator.

664-V3 - Prior Authorization Required Question

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
A code defining if the question must be answered for consideration of the Prior Authorization.	x(1)	F	Used in Formulary and Benefit Standard Version 2.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
Y	Answer required
N	Answer optional

665-V4 - Prior Authorization Response Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
A code indicating the data type of the response to the Prior Authorization question code.	x(35)	F	Used in Formulary and Benefit Standard Version 2.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
YesNo	Valid answers are 'Yes' or 'No'
Text	Answer can contain any alphanumeric text.
Date	Answer can be a date in either YYYY-MM-DD or YYYY-MM-DDTHH:MM:SS format.
Statement	A read-only statement from the payer. It should be displayed as text.
SelectOne	Indicates the answer should be one value from Prior Authorization Answer List Detail.
SelectMany	Indicates the answer should be one or more values from Prior Authorization Answer List Detail.

461-EU - Prior Authorization Type Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code clarifying the 'Prior Authorization Number Submitted' (462-EV) or benefit/plan exemption.	9(2)	T, A	

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Prior Authorization – a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependant upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product.
2	Medical Certification-A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment.
3	EPSDT (Early Periodic Screening Diagnosis Treatment)-Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required.
4	Exemption from Copay and/or Coinsurance - Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design.
5	Exemption from RX-Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time.
6	Family Planning Indicator-Code to indicate the drug prescribed is for management of reproduction.
7	TANF (Temporary Assistance for Needy Families) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs.
8	Payer Defined Exemption – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes.
9	Emergency Preparedness=Code used to override claim edits during an emergency situation.

299 - Processor Defined Prior Authorization Reason Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code clarifying the Prior Authorization Number.	9(2)	A	

Values:

CODE	DESCRIPTION
Ø	Not Specified

CODE	DESCRIPTION
1	Prior Authorization
2	Medical Certification
3	EPSDT (Early Periodic Screening Diagnosis Treatment)
4	Exemption from Copay
5	Exemption from Rx
6	Family Plan Indicator
7	TANF (Temporary Assistance for Needy Families)
8	Payer Defined Exemption

838-5U - Processor Location State

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The name of the state in which the processor is located, corresponding to field 84Ø-5W.	x(2)	C,D	

Values:

CODE	DESCRIPTION
See Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

395 - Processor Payment Clarification Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Provides additional information of the status of the payment of the claim.	x(2)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø1-Ø9	Paid
1Ø-19	Reversals
2Ø-29	Adjustments
3Ø-39	Rejects

6Ø1-19 - Product Code Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of data being submitted in the Product Code field.	x(1)	R,A	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Field was deleted in Manufacturer Rebates Standard Version Ø4.Ø1. Used in Post Adjudication Standard Version 2.Ø or greater but not in lower version.

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	This value may not be used in any versions of the Manufacturer Rebates Standard
1	First DataBank Formulation ID (GCN)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher

CODE	DESCRIPTION	Value Limitations
		versions.
2	Medi-Span Product Line Generic Product Identifier (GPI)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
3	First DataBank GC3	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
4	Medi-Span Product Line Drug Descriptor ID (DDID)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
5	First DataBank Medication Name Identifier (FDB Med Name ID)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
6	First DataBank Routed Medication Identifier (FDB Routed Med ID)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
7	First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
8	First DataBank Medication Identifier (FDB MedID)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
9	Nine-digit NDC	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
A	American Hospital Formulary Service (AHFS)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
C	Contracting organization (PMO) assigned code	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
G	First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
H	First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
M	Manufacturer (PICO) assigned code	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
N	Eleven-digit NDC	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
O	UPC (OTCS)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
P	Product group (brand or generic name)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
T	First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.
U	Universal System of Classification (USC)	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher

CODE	DESCRIPTION	Value Limitations
		versions.
Z	Mutually agreed upon code	Used in Manufacturer Rebates Standard Version Ø3.Ø2 only. Field was deleted for use by this standard and may not be used in higher versions.

6Ø1-22 - Product Formulary Status Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the formulary status of the product.	x(4)	R	

Values:

CODE	DESCRIPTION
1Ø1Ø	Preferred-For Brands: Branded Drugs listed as preferred. For Generics: All mandatory dispensing of generics and all drugs designated as MAC (Maximum Allowable Cost) drugs.
1Ø2Ø	Preferred/Restricted-Any preferred drug which has prescribing limitations that affect reimbursement. These limitations may include but are not limited to: prescriber specialty, patient age, indications, diagnoses, quantity, etc.
2Ø1Ø	Approved-Brands and/or Generics listed in the formulary without any qualifiers or restrictions.
3Ø1Ø	Restricted-Any approved drug which has prescribing limitations that affect reimbursement. These limitations may include, but are not limited to: prescriber specialty, patient age, indications, diagnoses, quantity, etc.
4Ø1Ø	Prior Authorization Required-Drugs which may be prescribed if the prescriber obtains prior approval from the plan.
5Ø1Ø	Not Reimbursed-Drugs which may be prescribed, but which will not be reimbursed by the plan. This includes when a product, form, or strength is not reimbursed, although the product's other forms and strengths are reimbursed.
5Ø2Ø	Not On Formulary-Drugs which are listed as "Not on Formulary" and cannot be prescribed.
6Ø1Ø	Exclusive-Brand or Generic listed in the formulary as the single product listed on formulary for the Therapeutic Category designated for the Brand or Generic.
7Ø1Ø	Covered-Brands and/or Generics not listed in the formulary, with the exception of copayments, are reimbursed without restriction and the NDC for the product is not blocked or prior authorized.
99Ø1	Other-Any other status not covered by definitions above. New codes, definitions and descriptions should be developed for anything classified as "Other".

436-E1 – Product/Service ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	x(2)	T,F,A,R,V	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Section II, Appendix B1 – Product/Service Qualifier	

959-HV - Product/Service ID Qualifier - Alternative

Definition of Field	Field Format	Standard/Version Formats	Field Limitations

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the value in Product/Service ID - Alternative	x(2)	F	

Values:

CODE	DESCRIPTION
See Section II, Appendix B1 – Product/Service Qualifier	

963-HZ - Product/Service ID Qualifier -Source

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the value in Product/Service ID - Source	x(2)	F	

Values:

CODE	DESCRIPTION
See Section II, Appendix B1 – Product/Service Qualifier	

961-HX - Product/Service ID Qualifier -Step Drug

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the value in Product/Service ID -Step Drug	x(2)	F	

Values:

CODE	DESCRIPTION
See Section II, Appendix B1 – Product/Service Qualifier	

964-JA - Product Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code to indicate the type of product.	x(1)	F	

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Single source —a clinical formulation that is only available from a single distributor.
2	Authorized Generic (aka “Branded Generic”)—the originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone.
3	Generic— the pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA).
4	O.T.C. (over the counter) —drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: “Caution: Federal Law Prohibits Dispensing Without a Prescription.”
5	Compound —a combination of pharmaceutical ingredients that is created extemporaneously; i.e. the combination is not available pre-packaged from a manufacturer.
6	Supply —consumable health care items, such as pledgets, syringes, test strips. Distinct from

CODE	DESCRIPTION
	Durable Medical Equipment (DME) which is generally not consumed by its use.
A	Any

44Ø-E5 - Professional Service Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	x(2)	T, A	

Values:

CODE	DESCRIPTION
ØØ	No intervention
AS	Patient assessment – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan.
CC	Coordination of care – Case management activities of a pharmacist related to the care being delivered by multiple providers.
DE	Dosing evaluation/determination –Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation.
FE	Formulary enforcement-Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange.
GP	Generic product selection-The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer.
MA	Medication administration – Code indicating an action of supplying a medication to a patient through any of several routes—oral, topical, intravenous, intramuscular, intranasal, etc.
MØ	Prescriber consulted – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem.
MR	Medication review-Code indicating comprehensive review and evaluation of a patient's entire medication regimen.
PE	Patient education/instruction – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management.
PH	Patient medication history – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile.
PM	Patient monitoring – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered.
PØ	Patient consulted – Code indicating patient communication related to collection of information or clarification of a specific limited problem.
PT	Perform laboratory test – Code indicating that the pharmacist performed a clinical laboratory test on a patient.
RØ	Pharmacist consulted other source -Code indicating communication related to collection of information or clarification of a specific limited problem.
RT	Recommend laboratory test –Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient.
SC	Self-care consultation – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment.
SW	Literature search/review – Code indicating that the pharmacist searches or reviews the

CODE	DESCRIPTION
	pharmaceutical and/or medical literature for information related to the care of a patient.
TC	Payer/processor consulted – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient.
TH	Therapeutic product interchange – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer.

361-2D – Provider Accept Assignment Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating whether the provider accepts assignment.	x(1)	T	Used in Telecommunication Standard Version C.2 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
Y	Assigned – Provider accepts assignment
N	Not Assigned – Provider does not accept assignment

465-EY - Provider ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Provider ID' (444-E9).	x(2)	T	

Values:

CODE	DESCRIPTION	Value Limitation
Blank	Not Specified	Used only in Telecommunication Standard Version 9.Ø and C.4. Field was deleted in Telecommunication Standard Version D.Ø.
Ø1	Drug Enforcement Administration (DEA)- The number assigned by the DEA to all businesses that manufacturer or distribute controlled pharmaceuticals, all health professionals who dispense, administer, or prescribe controlled pharmaceuticals an all pharmacies that fill prescriptions.	
Ø2	State License - The number assigned and required by a State Board or other State regulatory agency that uniquely identifies a pharmacy by category, as defined by each State or Territory or a prescriber by practice specialty for which they reside/practice.	
Ø3	Social Security Number (SSN) - Code indicating that the information to follow is the 9-digit number assigned to an individual by the Social Security Administration for various purposes, including paying and reporting taxes.	
Ø4	Name – Indicates the provider's name is used as the ID for the provider.	
Ø5	National Provider Identifier (NPI) –A HIPAA-mandated standard unique health identifier for health care providers	
Ø6	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.	
Ø7	State Issued - a unique number issued by a state program or organization other than Medicaid, to a provider of service.	
99	Other –Different from those implied or specified.	

439-E4 - Reason for Service Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	T, A	

Values:

CODE	DESCRIPTION
AD	Additional Drug Needed - Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy
AN	Prescription Authentication –Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription.
AR	Adverse Drug Reaction – Code indicating an adverse reaction by a patient to a drug.
AT	Additive Toxicity – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself.
CD	Chronic Disease Management – The patient is participating in a coordinated health care intervention program.
CH	Call Help Desk – Processor message to recommend the receiver contact the processor/plan
CS	Patient Complaint/Symptom- Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment.
DA	Drug-Allergy – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question.
DC	Drug-Disease (Inferred)-Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history.
DD	Drug-Drug Interaction-Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately.
DF	Drug-Food interaction-Indicates interactions between a drug and certain foods.
DI	Drug Incompatibility-Indicates physical and chemical incompatibilities between two or more drugs.
DL	Drug-Lab Conflict –Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value.
DM	Apparent Drug Misuse – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber.
DS	Tobacco Use – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products.
ED	Patient Education/Instruction –Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient beyond the simple task of explaining the prescriber's instructions on the prescription.
ER	Overuse – Code indicating that the current prescription refill is occurring before the days supply of the previous filling should have been exhausted.
EX	Excessive Quantity-Code that documents the quantity is excessive for the single time period for which the drug is being prescribed.

CODE	DESCRIPTION
HD	High Dose-Detects drug doses that fall above the standard dosing range.
IC	Iatrogenic Condition-Code indicating that a possible inappropriate use of drugs that are designed to amerliorate complications caused by another medication has been detected.
ID	Ingredient Duplication- Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected.
LD	Low Dose –Code indicating that the submitted drug doses fall below the standard dosing range.
LK	Lock In Recipient – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is “locked in” to using only those providers or pharmacies.
LR	Underuse – Code indicating that a prescription refill that occurred after the days supply of the previous filling should have been exhausted.
MC	Drug-Disease (Reported)- Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist.
MN	Insufficient Duration – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product’s common uses, has been detected.
MS	Missing Information/Clarification-Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information.
MX	Excessive Duration- Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product’s common uses.
NA	Drug Not Available-Indicates the drug is not currently available from any source.
NC	Non-covered Drug Purchase-Code indicating a cognitive service whereby a patient is counseled, the pharmacist’s recommendation is accepted and a claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug.
ND	New Disease/Diagnosis-Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease.
NF	Non-Formulary Drug-Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient’s pharmacy benefit plan.
NN	Unnecessary Drug – Code indicating that the drug is no longer needed by the patient.
NP	New Patient Processing-Code indicating that a pharmacist has performed the initial interview and medication history of a new patient.
NR	Lactation/Nursing Interaction-Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant.
NS	Insufficient Quantity- Code indicating that the quantity of dosage units prescribed is insufficient.
OH	Alcohol Conflict - Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages
PA	Drug-Age- Indicates age-dependent drug problems.
PC	Patient Question/Concern –Code indicating that a request for information/concern was expressed by the patient, with respect to patient care.
PG	Drug-Pregnancy-Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus.
PH	Preventive Health Care – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems.
PN	Prescriber Consultation –Code indicating that a prescriber has requested information or a recommendation related to the care of a patient.

CODE	DESCRIPTION
PP	Plan Protocol – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided.
PR	Prior Adverse Reaction – Code identifying the patient has had a previous atypical reaction to drugs.
PS	Product Selection Opportunity – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists.
RE	Suspected Environmental Risk- Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors.
RF	Health Provider Referral-Patient referred to the pharmacist by another health care provider for disease specific or general purposes.
SC	Suboptimal Compliance – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance.
SD	Suboptimal Drug/Indication- Code indicating incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition.
SE	Side Effect – Code reporting possible major side effects of the prescribed drug.
SF	Suboptimal Dosage Form – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug.
SR	Suboptimal Regimen – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question.
SX	Drug-Gender- Indicates the therapy is inappropriate or contraindicated in either males or females.
TD	Therapeutic – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected.
TN	Laboratory Test Needed –Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy.
TP	Payer/Processor Question Code indicating that a payer or processor requested information related to the care of a patient.

6Ø2-Ø5 - Rebate Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The type of rebate being paid.	x(3)	R	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Field was deleted in Manufacturer Rebates Standard Version Ø4.Ø1. Changes to this data element values must also be made to 6Ø2-Ø6-Rebate Type Description

Values:

CODE	DESCRIPTION
ØØ1	Administrative Fee
ØØ2	Aggregate Formulary
ØØ3	Aggregate Therapeutic Market Share
ØØ4	Baseline Market Share
ØØ5	Compliance Rebate
ØØ6	Discount Price Guarantee
ØØ7	Dollar Volume

CODE	DESCRIPTION
ØØ8	Dosage Guarantee
ØØ9	Fixed Discount
Ø1Ø	Individual Formulary
Ø11	Individual Therapeutic Market Share
Ø12	Market Share
Ø13	National Market Share
Ø14	Per Member Per Month (PMPM)
Ø15	Per Member Per Quarter (PMPQ)
Ø16	Per Member Per Year (PMPY)
Ø17	Performance-Based
Ø18	Risk Share
Ø19	Standard Dollar
Ø2Ø	Unit Volume
Ø21	Volume Fixed Discount
Ø22	Volume Tier
Z__	Mutually Agreed Upon Rebate Types (All codes beginning with the letter Z are reserved for use between trading partners.)

6Ø2-Ø6 - Rebate Type Description

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
A description of the 'Rebate Type' (6Ø2-Ø5) for the amount being paid.	x(3Ø)	R	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Field was deleted in Manufacturer Rebates Standard Version Ø4.Ø1. Changes to this data element values must also be made to 6Ø2-Ø5-Rebate Type

Values:

CODE	DESCRIPTION
ØØ1	Administrative Fee
ØØ2	Aggregate Formulary
ØØ3	Aggregate Therapeutic Market Share
ØØ4	Baseline Market Share
ØØ5	Compliance Rebate
ØØ6	Discount Price Guarantee
ØØ7	Dollar Volume
ØØ8	Dosage Guarantee
ØØ9	Fixed Discount
Ø1Ø	Individual Formulary
Ø11	Individual Therapeutic Market Share
Ø12	Market Share
Ø13	National Market Share
Ø14	Per Member Per Month (PMPM)
Ø15	Per Member Per Quarter (PMPQ)
Ø16	Per Member Per Year (PMPY)
Ø17	Performance-Based

CODE	DESCRIPTION
Ø18	Risk Share
Ø19	Standard Dollar

6Ø1-Ø3 Rebate Version Release Number

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Version and release number of standard being submitted.	x(5)	R	

Values:

CODE	DESCRIPTION
Ø1.Ø1	Version Ø1.Ø1
Ø2.Ø1	Version Ø2.Ø1
Ø3.Ø1	Version Ø3.Ø1
Ø3.Ø2	Version Ø3.Ø2
Ø4.Ø1	Version Ø4.Ø1

6Ø2-1Ø – Reconciliation Reason Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
This code indicates the reason for the dispute.	x(3)	R	

Values:

CODE	DESCRIPTION
See Appendix D – Reconciliation Reason Codes for Header and Trailer Records See Appendix E – Reconciliation Reason Codes for Detail and Rebate Records See Appendix F – CMS Reconciliation Reason Codes for Detail (RS) Records	

6Ø2-11 Reconciliation Status Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates how the line is being adjudicated.	x(1)	R	

Values:

CODE	DESCRIPTION
P	Paid As Submitted
A	Adjusted – Submitted line was modified
R	Rejected – Submitted line was denied

398 – Record Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Action to be taken on the record.	x(1)	A	

Values:

CODE	DESCRIPTION

CODE	DESCRIPTION
Blank	Not Specified
Ø	New record
1	Overwrite existing record
2	Delete existing record

6Ø1-53 Record Purpose Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the purpose of the record being submitted.	x(1)	R	

Values:

CODE	DESCRIPTION
M	Submitted for market share calculation
O	Other reported utilization
R	Submitted for rebate utilization

399 – Record Status Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the transaction status as assigned by the processor.	x(1)	A	

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Post Adjudication Standard Version 1.Ø. Value was deleted in Post Adjudication Standard Version 2.Ø and may not be used in higher versions of the standard.
1	Paid - Code indicating that the transaction was adjudicated using plan rules and was payable.	
2	Rejected - Code indicating that the transaction was denied/rejected	
3	Reversed - Code indicating that the paid transaction was cancelled	
4	Adjusted - Code indicating that the previous transaction was changed	
5	Captured - Code indicating the receipt of the transaction but no judgment has been made regarding eligibility of the patient or payment.	
6	Reverse – Captured- Code indicating that the captured transaction was cancelled.	

6Ø1-Ø4- Record Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Type of record being submitted.	x(2) ----------	R, A,V ----------	

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
	x(3)	F	

Values: For R

CODE	DESCRIPTION	Value Limitations
AD	Adjudicator	
FB	Formulary Benefit Design	
FO	Formulary	
FP	Formulary Product	
HD	Header	
MB	Market Basket Record	
MP	Market Product Record	
MO	Mail Order	
PD	Plan Detail	
RD	Reconciliation Detail Record	
RS	Reconciliation Detail State Format	
RT	Rebate Type Record	Used only in Manufacturer Rebates Standard Version Ø3.Ø2. Value was deleted and cannot be used in higher versions.
TR	Trailer	
UD	Utilization Detail	
US	Utilization Detail state Format	

Values: For A

CODE	DESCRIPTION
CD	Post Adjudication History Compound Detail Record1
CE	Post Adjudication History Compound Detail Record2
DE	Post Adjudication History Detail Record
PA	Post Adjudication History Header Record
PT	Post Adjudication History Trailer Record
PU	Post Adjudication Utilization Detail Record
PW	Post Adjudication Utilization Header Record
PX	Post Adjudication Utilization Compound Detail Record
PY	Post Adjudication Utilization Trailer Record

Values: For V

CODE	DESCRIPTION
RA	Prescription Transfer Header Record
XT	Prescription Transfer Trailer Record
SR	Sending/Receiving Pharmacy Record
ST	Sending/Receiving Pharmacy Total Record
RH	Prescription Header Record RX = Prescription Record
RZ	Prescription Trailer Record
PH	Prescriber Header Record
PR	Prescriber Record
PZ	Prescriber Trailer Record
MH	Medication Header Record
MR	Medication Record

CODE	DESCRIPTION
MZ	Medication Trailer Record
ZH	Patient Header Record
ZX	Patient Record
ZZ	Patient Trailer Record
FH	Fill Header Record
FR	Fill Record
FZ	Fill Trailer Record
TH	Third Party Payer Header Record
IT	Third Party Payer Record
IZ	Third Party Payer Trailer Record

Values: For F

CODE	DESCRIPTION
ADT	Formulary Alternatives Detail
AHD	Formulary Alternatives Header
ATR	Formulary Alternatives Trailer
CDT	Copay Information Detail
CRT	Copay Information Detail -Drug-Specific (DS)
CHD	Copay Header
CTR	Copay Trailer
DDT	Coverage Information Detail -Product Coverage Exclusion (DE), Prior Authorization (PA), Medical Necessity (MN)
FDT	Formulary Status Detail
FHD	Formulary Status Header
FTR	Formulary Status Trailer
GDA	Coverage Information Detail
GDT	Coverage Information Detail -Gender Limits(GL)
GHD	Coverage Information Header GTR
GTR	Coverage Information Trailer
HDR	Formulary And Benefit File Header
LDT	Drug Classification Detail
LHD	Drug Classification Header
LTR	Drug Classification Trailer
MDT	Coverage Information Detail -Step Medications (SM)
PAD	Prior Authorization Applicability List Detail
PAH	Prior Authorization Applicability List
PAT	Prior Authorization Applicability List Trailer
PDD	Prior Authorization Drug ID Form List Detail
PDH	Prior Authorization Drug ID Form List
PDT	Prior Authorization Drug ID Form List Trailer
PFD	Prior Authorization Form List Detail
PFH	Prior Authorization Form List
PFT	Prior Authorization Form List Trailer
PQD	Prior Authorization Question List Detail
PQH	Prior Authorization Question List
PQT	Prior Authorization Question List Trailer

CODE	DESCRIPTION
PTD	Prior Authorization Answer List Detail
PTH	Prior Authorization Answer List
PTT	Prior Authorization Answer List Trailer
QDT	Coverage Information Detail -Quantity Limits (QL)
RDT	RDT = Coverage Information Detail -Resource Link - Summary Level (RS)
RRT	RRT = Coverage Information Detail – Resource Link – Drug-Specific Level (RD)
SDT	SDT = Formulary & Benefit Response File Detail
SHD	SHD = Formulary & Benefit Response File Header
STR	STR = Formulary & Benefit Response File Trailer
TDT	Coverage Text Message
TRL	Formulary & Benefit File Trailer
XDT	Cross Reference List Detail
XHD	Cross Reference List Header
XTR	Cross Reference List Trailer

6Ø1-48 Reimbursement Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the content of the data submitted in the 'Reimbursement Amount' (6Ø1-47) field.	x(2)	R	Used in Manufacturer Rebates Standard Version Ø4.Ø1 or greater but not in lower versions. For Manufacturer Rebates Standard Version Ø3.Ø2 only the old field name of Plan Reimbursement Qualifier must be used.

Values:

CODE	DESCRIPTION
1	Includes dispensing fee
2	Excludes dispensing fee Paid

511-FB - Reject Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the error encountered.	x(3) --------- x(4)	T,A,V, N ---------- F	

Values:

CODE	DESCRIPTION
See Appendix A1 – Reject Codes See Appendix A2 – Formulary and Benefit Reject Codes	

878 – Reject Override Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the reason for paying a claim when override is used.	x(1)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø	Claim Was Paid In Good Faith
1	Member Was Ineligible On Rx Date
2	Member Was Not Found On The Member Master On Rx Date
3	Claim Was Filled For A Terminated Member

373-2U - Request Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying type of request.	x(1)	T	Used in Telecommunication Standard Version C.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Initial - Status indicating that an event, transaction, item, etc. is occurring at the very beginning; first.
2	Revision - A status indicating a modification
3	Recertification - A status indicating a renewal of a certification.

498-PA - Request Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying type of prior authorization request.	x(1)	T	

Values:

CODE	DESCRIPTION
1	Initial - Status indicating that an event, transaction, item, etc. is occurring at the very beginning; first.
2	Reauthorization- A status indicating a renewal of an authorization.
3	Deferred – Status indicating request is related to a deferred response status which indicates that the final determination of the previous prior authorization request can not be made until additional medical information is obtained. The request contains the additional medical information requested in the deferred response.

968-JF - Resource Link Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the type of coverage information contained at the URL contained in URL (987-MA).	x(2)	F	

Values:

CODE	DESCRIPTION
AL	Age Limits - Indicator used to convey that age constraints apply to the coverage of the specified product or list of products, to limit use to certain populations based on cost and availability of appropriate alternative therapies.

CODE	DESCRIPTION
CP	Copay - Indicator used to convey that the patient is responsible for a fixed dollar amount (copay) for the specified product or list of products regardless of the patient's current benefit status, product selection or network selection.
DE	Product Coverage Exclusion - Indicator used to convey that the specified product or a list of products is excluded from being paid by the plan rules.
FM	Formulary– Indicator used to convey a list maintained and provided by a health plan, pharmacy benefit manager or payer that identifies products/prescription drugs as covered, covered with limitations and/or prior authorization, or not covered. The formulary may identify alternate products for substitution of non-covered products.
GI	General Info - Indicator used to convey information related to the administration of the formulary by the health plan, pharmacy benefit manager or payer including information for contact, prior authorization and appeals.
GL	Gender Limits - Indicator used to convey that gender constraints apply to the coverage of the specified product or list of products, i.e., the product is allowed only for males or only for females.
MN	Medical Necessity - Indicator used to convey that medically necessary constraints apply to the coverage of the specified product or list of products, i.e. criteria requiring or excluding specific related diagnoses, failed treatment attempts, functional limitations, etc.
PA	Prior Authorization - Indicator used to convey that coverage of a product or list of products is dependant upon the prescriber submitting the request for coverage (including specified, required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product.
QL	Quantity Limits - Indicator used to convey that quantity constraints apply to the coverage of the specified product or list of products, e.g. the maximum allowed quantity of Viagra is 3 tablets per month.
ST	Step Therapy - Indicator used to convey that step therapy constraints apply to the coverage of the specified product or list of products. The step medications are not listed.

441-E6 - Result of Service Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	x(2)	T, A	

Values:

CODE	DESCRIPTION
ØØ	Not Specified
1A	Filled As Is, False Positive-Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and determines the alert is incorrect for that prescription for that patient and fills the prescription as originally written.
1B	Filled Prescription As Is-Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and determines the alert is not relevant for that prescription for that patient and fills the prescription as originally written.
1C	Filled, With Different Dose- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dose than was originally prescribed.
1D	Filled, With Different Directions – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with different directions than were originally prescribed.
1E	Filled, With Different Drug- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different drug than was originally prescribed.
1F	Filled, With Different Quantity – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different quantity than was originally prescribed.
1G	Filled, With Prescriber Approval Cognitive service whereby the pharmacist reviews and evaluates a

CODE	DESCRIPTION
	therapeutic issue (alert) and fills the prescription after consulting with or obtaining approval from the prescriber.
1H	Brand-to-Generic Change – Action whereby a pharmacist dispenses the generic formulation of an originally prescribed branded product. Allowed, often mandated, unless the prescriber indicates “Do Not Substitute” on the prescription
1J	Rx-to-OTC Change – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) fills the prescription with an over-the-counter product in lieu of the originally prescribed prescription-only product.
1K	Filled with Different Dosage Form- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed.
2A	Prescription Not Filled - Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written.
2B	Not Filled, Directions Clarified-Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber’s instructions.
3A	Recommendation Accepted – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber.
3B	Recommendation Not Accepted - Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur.
3C	Discontinued Drug- Cognitive service involving the pharmacist’s review of drug therapy that results in the removal of a medication from the therapeutic regimen.
3D	Regimen Changed - Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the recommended medication(s) after consultation with the prescriber.
3E	Therapy Changed – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber.
3F	Therapy Changed-cost increased acknowledged - Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber.
3G	Drug Therapy Unchanged-Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written.
3H	Follow-Up/Report – Code indicating that additional follow through by the pharmacist is required
3J	Patient Referral – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist.
3K	Instructions Understood – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed.
3M	Compliance Aid Provided – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications.
3N	Medication Administered-Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication.

995-E2 - Route Of Administration

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
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	x(11)	T,A	Used in Telecommunication Standard Version C.4 or greater but not in lower versions. Used in Post Adjudication Standard Version 2.Ø or greater but not in

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
mixture.			lower version.

Values:

CODE DESCRIPTION
Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the College of American Pathologists, Northfield, Illinois http://www.snomed.org/

111-AM Segment Identification

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies the segment in the request and/or response.	x(2)	T,N	

Values: For T

CODE	DESCRIPTION
Ø1	Patient
Ø2	Pharmacy Provider
Ø3	Prescriber
Ø4	Insurance
Ø5	Coordination of Benefits/Other Payments
Ø6	Worker's Compensation
Ø7	Claim
Ø8	DUR/PPS
Ø9	Coupon
1Ø	Compound
11	Pricing
12	Prior Authorization
13	Clinical
14	Additional Documentation
15	Facility
16	Narrative
2Ø	Response Message
21	Response Status
22	Response Claim
23	Response Pricing
24	Response DUR/PPS
25	Response Insurance
26	Response Prior Authorization
27	Response Insurance Additional Information
28	Response Coordination of Benefits/Other Payers
29	Response Patient

Values: For N

CODE	DESCRIPTION

CODE	DESCRIPTION
Ø1	Patient
3Ø	Financial Information Reporting Request Insurance
31	Request Reference
32	Request Financial
33	Financial Information Reporting Response Message
34	Financial Information Reporting Response Status
35	Response Financial

7Ø1 Segment Identifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Unique record type required on Enrollment/Batch Transaction Standard.	x(2)	B	

Values:

CODE	DESCRIPTION
ØØ	File Control
G1	Detail Data Record
99	File Trailer

644-XR Segment Qualifier 1

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates for the Segment Field the definition of how the rebates are stratified in the batch number.	X(2)	R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
1	Hierarchy Level 1- Trading Partner Defined
2	Hierarchy Level 2 - Trading Partner Defined
3	Hierarchy Level 3 - Trading Partner Defined
4	Hierarchy Level 4 - Trading Partner Defined
5	Hierarchy Level 5 -Trading Partner Defined
6	Hierarchy Level 6 - Trading Partner Defined
A	Benefit Category - Trading Partner Defined
B	Benefit Tier - Trading Partner Defined
D	CMS assigned contract ID - The contract number assigned by Centers for Medicare and Medicaid Services (CMS) for a Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug (MAPD) contract
E	PBP Number- The number used to identify the Primary benefit provider.
F	Formulary Control – The level of formulary management occurring.
L	Line of Business - The type of business segment represented for the client.
LS	Low income subsidy level (LICS) – Indicator used by CMS to describe the PDP or MAPD plan benefit level for the patient.
M	Mail Indicator – Indicator used by Trading Partners to indicate prescription was filled by a mail order facility

CODE	DESCRIPTION
P	Benefit Plan Level (BPL) – Indicator used by Trading Partners to identity the coverage category the patient is eligible for when the prescription was filled.
RD	Rider - Trading Partner Defined
RI	Retail Indicator - Indicator used by Trading Partners to indicate prescription was filled by a retail facility
RS	Retiree Drug Sub plan – Defined by CMS and agreed upon by Trading Partners
T	Plan Type Category - A type of plan segment designation within a client level.
Z	Trading Partner Mutually Defined

645-XS Segment Qualifier 2

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates for the Segment Field the definition of how the rebates are stratified in the batch number.	X(2)	R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Segment Qualifier 1 (644-XR) values.	

646-XT Segment Qualifier 3

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates for the Segment Field the definition of how the rebates are stratified in the batch number.	X(2)	R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Segment Qualifier 1 (644-XR) values.	

647-XU Segment Qualifier 4

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates for the Segment Field the definition of how the rebates are stratified in the batch number.	X(2)	R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Segment Qualifier 1 (644-XR) values.	

648-XV Segment Qualifier 5

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates for the Segment Field the definition of how the rebates are stratified in the batch number.	X(2)	R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Segment Qualifier 1 (644-XR) values.	

649-XW Segment Qualifier 6

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates for the Segment Field the definition of how the rebates are stratified in the batch number.	X(2)	R	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Segment Qualifier 1 (644-XR) values.	

2Ø2-B2 – Service Provider ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	T, A, R,V	Used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted for use in higher versions of these standards.
Ø1	National Provider Identifier (NPI) = a standard unique health identifier for health care providers. The NPI is a 1Ø position numeric identifier with a check digit in the 1Øth position and is assigned by the National Provider System (NPS).	
Ø2	Blue Cross = a number assigned by a Blue Cross health plan which is a nonprofit hospital expense prepayment plan primarily designed to provide benefits for hospitalization coverage, with certain restrictions on the accommodations to be used.	
Ø3	Blue Shield = a number assigned by a Blue Shield health plan which is a prepayment plan offered by voluntary nonprofit organizations that cover medical and surgical expenses.	
Ø4	Medicare = a number assigned by the carrier or intermediary which administers the Medicare health insurance program for people age 65 or older, some people with disabilities under age 65, and people with end-stage renal disease. Medicare has two parts, hospital insurance (Part A) and medical insurance (Part B).	
Ø5	Medicaid = a number assigned to a provider by a state Medicaid agency. Each state has a unique identifier. Medicaid is a program established pursuant to Title XIX of the Social Security Act to provide medical benefits for certain categories of low-income individuals. The program provides benefits to indigent and disabled individuals and members of families receiving Aid to Families with Dependent Children. States have the option to provide benefits to a broader range of individuals. The program is a cooperative arrangement between the federal government and the states, under which both the federal government and a participating state contribute financial support. The	

CODE	DESCRIPTION	Value Limitations
	state, however, retains a considerable amount of discretion over the operation and administration of the program, and has the right to determine the benefits to be provided, rules for eligibility, rates of payment for services and other matters, as long as broad regulatory guidelines established by the federal government are followed.	
Ø6	UPIN (Unique Physician/Practitioner Identification Number) = a number assigned to each Medicare physician/practitioner to identify the referring or ordering physician on Medicare claims. UPINs consist of an alpha character and five numerics and is assigned by CMS.	
Ø7	NCPDP Provider ID (National Council for Prescription Drug Programs Provider Identification Number) = a number that provides pharmacies with a unique, 7 digit national identifying number that assists pharmacies in their interactions with federal agencies and third party providers. The NCPDP Provider Identification Number was formerly known as the NABP (National Board of Pharmacy) number. NCPDP also enumerates licensed dispensing sites in the United States as part of its Alternate Site Enumeration Program Numbering System (ASEP). The purpose of this system is to enable a site to identify itself to all third part processors by one standard number, in order to adjudicate claims and receive reimbursement from prescription card programs.	
Ø8	State License = the number assigned and required by a State Board or other State regulatory agency that uniquely identifies a pharmacy by category, as defined by each State or Territory or a prescriber by practice specialty for which they reside/practice.	
Ø9	CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) = a number that uniquely identifies a provider that participates in the CHAMPUS program which is a federal medical benefits program that helps pay for civilian medical care rendered to the spouses and children of active duty and retired personnel.	
1Ø	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.	
11	Federal Tax ID = a 9-digit number assigned by the Internal Revenue Service to sole proprietors, corporations, partnerships, estates, trusts, and other entities for the purpose of tax filing and reporting.	
12	Drug Enforcement Administration (DEA) = the number assigned by the DEA to all businesses that manufacture or distribute controlled pharmaceuticals, all health professionals who dispense, administer, or prescribe controlled pharmaceuticals and all pharmacies that fill prescriptions.	
13	State Issued = a unique number issued by a state program or organization other than Medicaid, to a provider of service.	
14	Plan Specific = a unique proprietary number assigned by a commercial health care plan to a provider of service.	
15	HCID (HC IDea) = A 1Ø-character, alphanumeric identifier assigned by NCPDP to identify authorized prescribers of drugs	
99	Other = used to identify other health plans and enumerating organizations not listed above.	

334-1C - Smoker/Non-Smoker Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the patient as a smoker or non-smoker.	*x(1)*	M,T,V	

Values:

CODE	DESCRIPTION
Blank	Not Specified
1	Non-Smoker - a person who doesn't smoke

CODE	DESCRIPTION
2	Smoker - a person who smokes

429-DT –Special Packaging Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the type of dispensing dose.	9(1)	C, P, D, T, A	Used in Telecommunication Standard Version C.4 or greater and Post Adjudication Standard Version 2.Ø greater but not in lower versions. For Telecommunication Standard Version 9.Ø through C.3 and Post Adjudication Standard Version 1.Ø the old field name of Unit Dose must be used.

Values:

CODE	DESCRIPTION
Ø	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	Custom Packaging – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly.
5	Multi-drug compliance packaging (Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration)

729 - State

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Abbreviation of state in which member resides.	x(2)	M, R, A	

Values:

CODE	DESCRIPTION
See Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	

974-JN - Step Order

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The suggested order in which the step medication is to be tried	x(1)	F	

Values:

CODE	DESCRIPTION
1	First to be tried

CODE	DESCRIPTION
2	Second to be tried
3	Third to be tried
4	Fourth to be tried
5	Fifth to be tried
6	Sixth to be tried
7	Seventh to be tried
8	Eighth to be tried
9	Ninth to be tried

42Ø-DK – Submission Clarification Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating that the pharmacist is clarifying the submission.	9(2)	T, P, A	

Values:

CODE	DESCRIPTION	Value Limitations
Ø	Not Specified, Default	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
1	No Override	
2	Other Override	
3	Vacation Supply-The pharmacist is indicating that the cardholder has requested a vacation supply of the medicine.	
4	Lost Prescription-The pharmacist is indicating that the cardholder has requested a replacement of medication that has been lost.	
5	Therapy Change-The pharmacist is indicating that the physician has determined that a change in therapy was required; either that the medication was used faster than expected, or a different dosage form is needed, etc.	
6	Starter Dose-The pharmacist is indicating that the previous medication was a starter dose and now additional medication is needed to continue treatment.	
7	Medically Necessary-The pharmacist is indicating that this medication has been determined by the physician to be medically necessary.	
8	Process Compound For Approved Ingredients	
9	Encounters	
1Ø	Meets Plan Limitations -The pharmacy certifies that the transaction is in compliance with the program's policies and rules that are specific to the particular product being billed.	
11	Certification on File – The supplier's guarantee that a copy of the paper certification, signed and dated by the physician, is on file at the supplier's office.	
12	DME Replacement Indicator – Indicator that this certification is for a DME item replacing a previously purchased DME item.	
13	Payer-Recognized Emergency/Disaster Assistance Request - The pharmacist is indicating that an override is needed based	

CODE	DESCRIPTION	Value Limitations
	on an emergency/disaster situation recognized by the payer.	
14	Long Term Care Leave of Absence - The pharmacist is indicating that the cardholder requires a short-fill of a prescription due to a leave of absence from the Long Term Care (LTC) facility.	
15	Long Term Care Replacement Medication - Medication has been contaminated during administration in a Long Term Care setting.	
16	Long Term Care Emergency box (kit) or automated dispensing machine – Indicates that the transaction is a replacement supply for doses previously dispensed to the patient after hours.	
17	Long Term Care Emergency supply remainder - Indicates that the transaction is for the remainder of the drug originally begun from an Emergency Kit.	
18	Long Term Care Patient Admit/Readmit Indicator - Indicates that the transaction is for a new dispensing of medication due to the patient's admission or readmission status.	
19	Split Billing - indicates the quantity dispensed is the remainder billed to a subsequent payer when Medicare Part A expires. Used only in long-term care settings.	
99	Other	

888 – Submission Number

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the number of times a data set has been resent.	x(2)	A	

Values:

CODE	DESCRIPTION
Blank	Not Specified
ØØ	Original Submission
Ø1	First resubmission
Ø2	Second resubmission
Ø3-99	Number of resubmission

6Ø1-36 – Submit Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The code on the file defining the type of submission for the entire batch (identified by the batch number). Indicates the action to perform on the submitted file.	x(2)	R	Used in Manufacturer Rebates Standard Version Ø4.Ø1 or greater but not in lower versions. For Manufacturer Rebates Standard Version Ø3.Ø2 only the old field name of FF Action Code must be used.

Values:

CODE	DESCRIPTION
ØØ	Original or initial submission of data - Signifies the data submitted for rebate as being the original submission of the prescription for rebate, as opposed to an adjustment or reversal of an original submission.
Ø2	Correction or Adjustment to previous submission rebate period - Code submitted by PMO within Utilization

CODE	DESCRIPTION
	Detail (UD) flat file to a PICO. Action Code Ø2 describes incremental or decremental adjustments where each UD Record nets with a corresponding previously submitted UD record. If a correction is being made to a signed Numeric Extended field, the sign of the number identifies the action (debit/credit). Alpha-numeric values replace previously submitted values.
Ø3	Delete entire previous submission rebate period - The code identifies transactions submitted by the PMO to the PICO for addition, deletion, or modification (based on the value of the Change Identifier field of the MP Record) of Market Basket Product (MP) Records for market basket records previously submitted.
Ø5	Replace entire previously submitted rebate period - An action code used to indicate the rebate records being submitted should be used in place of a batch of rebate records previously submitted.

557-AV Tax Exempt Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the payer and/or the patient is exempt from taxes.	x(1)	T,A	

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	
1	Payer/Plan is Tax Exempt =The Payer/Plan is not responsible for tax. The patient may be charged tax.	
2	Not Tax Exempt	Used only in Telecommunication Standard Versions 9.Ø through C.4. and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
3	Patient is Tax Exempt =The patient cannot be charged tax.	
4	Payer/Plan and Patient are Tax Exempt =Neither the payer/plan nor the patient can be charged tax.	

629-SH Telephone Number

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the type of telephone number.	x(2)	V	

Values:

CODE	DESCRIPTION
	SEE SECTION II - APPENDIX K – VALUES FOR COMMUNICATION CODES

6Ø1-26 - Therapeutic Class Code Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	x(1)	R,A	Used in Post Adjudication Standard Version 2.Ø or greater but not in lower version.

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Not used in Manufacturer Rebates

CODE	DESCRIPTION	Value Limitations
		Standard for any versions.
1	First DataBank Formulation ID (GCN)- A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution.	
2	Medi-Span Product Line Generic Product Identifier (GPI) -A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration.	
3	First DataBank GC3- A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified.	
4	Medi-Span Product Line Drug Descriptor ID (DDID)- Index terms and phrases assigned to each record to characterize the substantive content of the original drug.	
5	First DataBank Medication Name Identifier (FDB Med Name ID)- A permanent numeric identifier that represents a unique product or generic name.	
6	First DataBank Routed Medication Identifier (FDB Routed Med ID)-Represents the product or generic name and route of administration.	
7	First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)-Represents the product or generic name, route of administration, and dosage form.	
8	First DataBank Medication Identifier (FDB MedID)-A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure.	
9	First DataBank Enhanced Therapeutic Class Codes (ETC ID) – A system that allows drugs to reside in multiple therapeutic classes, with links to drug concepts at any level of the therapeutic class hierarchy. It links to Multiple Access Points (MAPs), and uses a wide variety of medication concept identifiers to support multiple use-case scenarios.	
A	American Hospital Formulary Service (AHFS) Code - Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications.	
C	Contracting Organization (PMO) Assigned Code - Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO.	
M	Manufacturer (PICO) Assigned Code –Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs))	
U	Universal System of Classification Code (USC) - A standard	

CODE	DESCRIPTION	Value Limitations
	classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated.	
Z	Mutually Agreed Upon Code- A code mutually agreed upon by trading partners to identify a given data type element.	

1Ø3-A3 Transaction Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the type of transaction.	x(2)	T,N	

Values: For T

CODE	DESCRIPTION
B1	Billing
B2	Reversal
B3	Rebill
C1	Controlled Substance Reporting
C2	Controlled Substance Reporting Reversal
C3	Controlled Substance Reporting Rebill
D1	Predetermination of Benefits
E1	Eligibility Verification
N1	Information Reporting
N2	Information Reporting Reversal
N3	Information Reporting Rebill
P1	P.A. Request & Billing
P2	P.A. Reversal
P3	P.A. Inquiry
P4	P.A. Request Only
S1	Service Billing
S2	Service Reversal
S3	Service Rebill

Values: For N

CODE	DESCRIPTION
F1	Financial Information Reporting Inquiry
F2	Financial Information Reporting Update
F3	Financial Information Reporting Exchange

1Ø9-A9 Transaction Count

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Count of transactions in the transmission.	x(1)	T,N	

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4. Value was deleted and cannot be used in

CODE	DESCRIPTION	Value Limitations
		higher versions.
1	One Occurrence	
2	Two Occurrences	
3	Three Occurrences	
4	Four Occurrences	

112-AN Transaction Response Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code indicating the status of the transaction.	x(1)	T,N	

Values: For T

CODE	DESCRIPTION
A	Approved - Code indicating that the transaction has been approved
B	Benefit - Code indicating benefit information returned
C	Captured - Code indicating that the transaction had been captured
D	Duplicate of Paid - Code indicating that the transaction was paid in a previously submitted transaction
F	PA Deferred - Code indicating that the prior authorization transaction cannot be processed until additional information is obtained
P	Paid - Code indicating that the transaction has been adjudicated using plan rules and was paid
Q	Duplicate of Capture – Code indicating that the transaction had been previously captured
R	Rejected - Code indicating that the transaction has been denied/rejected
S	Duplicate of Approved -Code indicating that the transaction was previously approved

Values: For N

CODE	DESCRIPTION
A	Approved - Code indicating that the transaction has been approved
R	Rejected - Code indicating that the transaction has been denied/rejected

631-SK Transfer Flag

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates previous transfer history of the prescription.	x(1)	V	

Values:

CODE	DESCRIPTION
Blank	Not Specified
Ø	No transfer history known
1	No previous transfer
2	Prescription has been transferred from another location
3	Prescription has been transferred to another location
4	Prescription has been transferred from another location and to another location

632-SM Transfer Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates file content.	9(1)	V	

Values:

CODE	DESCRIPTION
Ø	Not Specified
1	Open Refill (Refills remaining) - This indicates that the transfer file only contains prescriptions with remaining open refills. There will be one record for open refill. For example: If a prescription has been filled 3 times and has 2 more refills remaining, the file will contain one record indicating that 2 more refills are outstanding.
2	All Prescription Information (historical prescriptions included) - This indicate that the file being transferred contains not only prescriptions with open refills but historical information as well. For example: If a prescription has been filled 3 times, the file will contain 3 detailed records associated with this prescription.

981-JV - Transmission Action

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates whether this is a replacement file, file updates or a file delete	x(1)	F, A	

Values:

CODE	DESCRIPTION
F	Full Replace – A total substitute of the existing file
D	Delete - Remove the existing file
U	Update - Modify an existing file
O	Original Submission (New) - A new file
C	Correction/Adjustment to a previous batch - Modify a previously submitted batch
D	Deletion of a previous batch - Removal of a previously submitted batch
P	Replacement of a previous batch (delete followed by add) - The removal of an existing batch previously submitted with the addition of the submitted batch immediately following

986-KJ - Transmission File Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifier of the file type	x(3)	F	

Values:

CODE	DESCRIPTION
FRE	Formulary And Benefit Response
FRM	Formulary And Benefit Load

88Ø-K6 Transmission Type

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
A value to define the type of transmission being sent.	x(1)	B	

Values:

CODE	DESCRIPTION
T	Transaction - Code indicating the file contains submission transactions
R	Response - Code indicating the file contains response transactions
E	Error - Code indicating the entire file of transactions has been rejected by the receiver of the file

635-SQ Unique Record Identifier Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying Unique Record Identifier (634-SP).	9(2)	V	

Values:

CODE	DESCRIPTION
PR	Prescriber - Identifies the prescribers who prescribed the prescriptions being transferred on the file
MR	Medication - Identifies the drugs that are present in the Fill Records (FR))
ZX	Patient (Identifies all the patients for whom the drug products and/or services in the accompanying prescription file were prescribed
TT	Third Party - Identifies coverage information; not used in cash payment situations
RX	Prescription - Records that contain mandatory information used to identify information such as prescribed and dispensed information, compound code, etc.
FR	Fill - Identifies each fill, dispensing information, and applicable identifiers

6ØØ-28 – Unit of Measure

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
NCPDP standard product billing codes.	x(2)	R,T,A	

Values:

CODE	DESCRIPTION
EA	Each - Being one or individual.
GM	Grams - A metric unit of mass equal to one thousandth of a kilogram.
ML	Milliliters - A metric measure of volume equal to one thousandth of a liter.

1Ø2-A2 Version/Release Number

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	x(2)	A,B,T,F,G,V,N	

Values: For T

CODE	DESCRIPTION
1Ø	Version 1.Ø
2Ø	Version 2.Ø
3Ø	Version 3.Ø
31	Version 3.1

CODE	DESCRIPTION
32	Version 3.2
3A	Standard Claim/Reversal
3B	Workers Compensation
3C	Medicaid Claim/Reversal
33	Version 3.3
34	Version 3.4
35	Version 3.5
4Ø	Version 4.Ø
41	Version 4.1
42	Version 4.2
5Ø	Version 5.Ø
51	Version 5.1
52	Version 5.2
53	Version 5.3
54	Version 5.4
55	Version 5.5
56	Version 5.6
6Ø	Version 6.Ø
7Ø	Version 7.Ø
71	Version 7.1
8Ø	Version 8.Ø
81	Version 8.1
82	Version 8.2
83	Version 8.3
9Ø	Version 9.Ø
AØ	Version A.Ø
A1	Version A.1
BØ	Version B.Ø
CØ	Version C.Ø
C1	Version C.1
C2	Version C.2
C3	Version C.3
C4	Version C.4
DØ	Version D.Ø

Values: For B

CODE	DESCRIPTION
1Ø	Version 1.Ø
11	Version 1.1
12	Version 1.2

Values: For F,N,V

CODE	DESCRIPTION
1Ø	Version 1.Ø

Values: For A

CODE	DESCRIPTION
1Ø	Version 1.Ø

CODE	DESCRIPTION
2Ø	Version 2.Ø

Values: For G

CODE	DESCRIPTION
3Ø	Version 3.Ø

A. APPENDIX A - REJECT CODES FOR 511-FB

(NOTE: Reject Codes added for and pertaining to specific fields may not be used in versions of the standards that were in effect prior to the addition of the field(s) to the standards. Refer to the Standard/Version Formats Column of field 511-FB for Standards Use.)

1. REJECT CODES

Reject Code Explanations that contain the phrase "not supported".

Reject Codes which have explanations containing the phrase "not supported" are to be used when a segment is not supported, a type of identifier, or a code list is not supported. Processors/Payers should indicate either specifically or by omission on their payer sheets that these segments/identifier types/code lists are not supported. Please see “Note” below.

For example:
1. Patient ID Qualifier (331-CX) is required by the receiving entity, but the only value accepted is “Ø1” Social Security Number, and some other value is submitted.
2. Transaction Code (1Ø3-A3) is required, but the values “C1” Controlled Substance Reporting, “C2” (Controlled Substance Reporting Reversal), or “C3” (Controlled Substance Reporting Rebill) are submitted, which are not supported.
3. Segment Identification (111-AM) is required, but values “Ø9” (Coupon) and “1Ø” (Compound) are submitted, which are not supported.

Reject Code Explanations that contain the phrase "not covered".

Reject Codes which have explanations containing the phrase "not covered" are to be used when plan parameters specify that the particular value/situation to which it applies is not an allowable situation for processing consideration.

For example:
1. Product/Service ID (4Ø7-D7) is required by the receiving entity, but the NDC submitted is not allowed for this plan benefit.
2. Prescriber ID (411-DB) is required by the receiving entity, but the Prescriber ID submitted is not covered for this plan benefit.

Reject Code Explanations that contain the phrase "missing/invalid".

Reject Codes for Missing/Invalid data elements are to be used when either the data element, which should be submitted, is not submitted or the data submitted does not conform to the specified field format or defined field values.

For example:
1. Date of Service (4Ø1-D1) is required by the receiving entity, but the field submitted contains the invalid dates of 2ØØ4ABCD or 99999999 or ØØØØØØØØ.
2. Dispense As Written (DAW)/ Product Selection Code (4Ø8-D8) is required by the receiving entity, but the field is not submitted.

Note: It is important that should a value, identifier, segment, and/or situation be sent that has no impact on the adjudication or processing of the transaction(s), the submitted value, identifier, segment, and/or situation must be ignored by the receiving entity and must not be rejected.

REJECT CODES FOR TELECOMMUNICATION STANDARD

Reject Code	Explanation	Field # Possibly In Error	Field Limitation
ØØ	("M/I" Means Missing/Invalid)		
Ø1	M/I Bin Number	1Ø1	
Ø2	M/I Version/Release Number	1Ø2	
Ø3	M/I Transaction Code	1Ø3	
Ø4	M/I Processor Control Number	1Ø4	
Ø5	M/I Service Provider Number	2Ø1	
Ø6	M/I Group ID	3Ø1	
Ø7	M/I Cardholder ID	3Ø2	
Ø8	M/I Person Code	3Ø3	
Ø9	M/I Date Of Birth	3Ø4	
1C	M/I Smoker/Non-Smoker Code	334	
1E	M/I Prescriber Location Code	467	
1R	Version/Release Not Supported	1Ø2-A2	
1S	Transaction Code/Type Not Supported	1Ø3-A3	
1T	PCN Must Contain Processor/Payer Assigned Value	1Ø4-A4	
1U	Transaction Count Does Not Match Number of Transactions	1Ø9-A9	
1V	Multiple Transactions Not Supported	1Ø9-A9	
1W	Multi-Ingredient Compound Must Be A Single Transaction	1Ø9-A9	

REJECT CODES FOR TELECOMMUNICATION STANDARD

Reject Code	Explanation	Field # Possibly In Error	Field Limitation
1X	Vendor Not Certified For Processor/Payer	11Ø-AK	
1Y	Claim Segment Required For Adjudication	111-AM	
1Z	Clinical Segment Required For Adjudication	111-AM	
1Ø	M/I Patient Gender Code	3Ø5	
11	M/I Patient Relationship Code	3Ø6	
12	M/I Place of Service	3Ø7	Also applies to M/I Patient Location for Telecom Versions 9.Ø through A.1
13	M/I Other Coverage Code	3Ø8	
14	M/I Eligibility Clarification Code	3Ø9	
15	M/I Date of Service	4Ø1	
16	M/I Prescription/Service Reference Number	4Ø2	
17	M/I Fill Number	4Ø3	
19	M/I Days Supply	4Ø5	
2A	M/I Medigap ID	239	
2B	M/I Medicaid Indicator	36Ø	
2C	M/I Pregnancy Indicator	335	
2D	M/I Provider Accept Assignment Indicator	361	
2E	M/I Primary Care Provider ID Qualifier	468	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
2G	M/I Compound Ingredient Modifier Code Count	362	
2H	M/I Compound Ingredient Modifier Code	363	
2J	M/I Prescriber First Name	364	
2K	M/I Prescriber Street Address	365	
2M	M/I Prescriber City Address	366	
2N	M/I Prescriber State/Province Address	367	
2P	M/I Prescriber Zip/Postal Zone	368	
2Q	M/I Additional Documentation Type ID	369	
2R	M/I Length of Need	37Ø	
2S	M/I Length of Need Qualifier	371	
2T	M/I Prescriber/Supplier Date Signed	372	
2U	M/I Request Status	373	
2V	M/I Request Period Begin Date	374	
2W	M/I Request Period Recert/Revised Date	375	
2X	M/I Supporting Documentation	376	
2Z	M/I Question Number/Letter Count	377	
2Ø	M/I Compound Code	4Ø6	
21	M/I Product/Service ID	4Ø7, 489-TE	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
22	M/I Dispense As Written (DAW)/Product Selection Code	4Ø8	
23	M/I Ingredient Cost Submitted	4Ø9	
25	M/I Prescriber ID	411	
26	M/I Unit Of Measure	6ØØ	
28	M/I Date Prescription Written	414	
29	M/I Number Of Refills Authorized	415	
3A	M/I Request Type	498-PA	
3B	M/I Request Period Date-Begin	498-PB	
3C	M/I Request Period Date-End	498-PC	
3D	M/I Basis Of Request	498-PD	
3E	M/I Authorized Representative First Name	498-PE	
3F	M/I Authorized Representative Last Name	498-PF	
3G	M/I Authorized Representative Street Address	498-PG	
3H	M/I Authorized Representative City Address	498-PH	
3J	M/I Authorized Representative State/Province Address	498-PJ	
3K	M/I Authorized Representative Zip/Postal Zone	498-PK	
3M	M/I Prescriber Phone Number	498-PM	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
3N	M/I Prior Authorized Number-Assigned	498-PY	
3P	M/I Authorization Number	5Ø3	
3Q	M/I Facility Name	385	
3R	Prior Authorization Not Required	4Ø7	
3S	M/I Prior Authorization Supporting Documentation	498-PP	
3T	Active Prior Authorization Exists Resubmit At Expiration Of Prior Authorization		
3U	M/I Facility Street Address	386	
3V	M/I Facility State/Province Address	387	
3W	Prior Authorization In Process		
3X	Authorization Number Not Found	5Ø3	
3Y	Prior Authorization Denied		
32	M/I Level Of Service	418	
33	M/I Prescription Origin Code	419	
34	M/I Submission Clarification Code	42Ø	
35	M/I Primary Care Provider ID	421	
38	M/I Basis Of Cost Determination	423	Deleted Telecom VB.Ø Duplicate of reject code "DN"
39	M/I Diagnosis Code	424	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
4B	M/I Question Number/Letter	378	
4C	M/I Coordination Of Benefits/Other Payments Count	337	
4D	M/I Question Percent Response	379	
4E	M/I Primary Care Provider Last Name	57Ø	
4G	M/I Question Date Response	38Ø	
4H	M/I Question Dollar Amount Response	381	
4J	M/I Question Numeric Response	382	
4K	M/I Question Alphanumeric Response	383	
4M	Compound Ingredient Modifier Code Count Does Not Match Number of Repetitions	362	
4N	Question Number/Letter Count Does Not Match Number of Repetitions	377	
4P	Question Number/Letter Not Valid for Identified Document	378	
4Q	Question Response Not Appropriate for Question Number/Letter	378	
4R	Required Question Number/Letter Response for Indicated Document Missing	378	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
4S	Compound Product ID Requires a Modifier Code		
4T	M/I Additional Documentation Segment	111	
4W	Must Fill Through Specialty Pharmacy	4Ø7, 489	
4X	M/I Patient Residence	384-4X	
4Y	Patient Residence not supported by plan	384-4X	
4Z	Place of Service Not Support By Plan	3Ø7-C7	
4Ø	Pharmacy Not Contracted With Plan On Date Of Service	None	
41	Submit Bill To Other Processor Or Primary Payer	None	
5C	M/I Other Payer Coverage Type	338	
5E	M/I Other Payer Reject Count	471	
5J	M/I Facility City Address	388	
5Ø	Non-Matched Pharmacy Number	2Ø1	
51	Non-Matched Group ID	3Ø1	
52	Non-Matched Cardholder ID	3Ø2	
53	Non-Matched Person Code	3Ø3	
54	Non-Matched Product/Service ID Number	4Ø7, 489-TE	
55	Non-Matched Product Package Size	4Ø7, 489-TE	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
56	Non-Matched Prescriber ID	411	
58	Non-Matched Primary Prescriber	421	
6C	M/I Other Payer ID Qualifier	339	
6D	M/I Facility Zip/Postal Zone	389	
6E	M/I Other Payer Reject Code	472	
6G	Coordination Of Benefits/Other Payments Segment Required For Adjudication	111-AM	
6H	Coupon Segment Required For Adjudication	111-AM	
6J	Insurance Segment Required For Adjudication,	111-AM	
6K	Patient Segment Required For Adjudication	111-AM	
6M	Pharmacy Provider Segment Required For Adjudication	111-AM	
6N	Prescriber Segment Required For Adjudication	111-AM	
6P	Pricing Segment Required For Adjudication	111-AM	
6Q	Prior Authorization Segment Required For Adjudication	111-AM	
6R	Worker's Compensation Segment Required For Adjudication	111-AM	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
6S	Transaction Segment Required For Adjudication	111-AM	
6T	Compound Segment Required For Adjudication	111-AM	
6U	Compound Segment Incorrectly Formatted	111-AM	
6V	Multi-ingredient Compounds Not Supported,	111-AM	
6W	DUR/PPS Segment Required For Adjudication	111-AM	
6X	DUR/PPS Segment Incorrectly Formatted	111-AM	
6Y	Not Authorized To Submit Electronically	2Ø1-B1	
6Z	Provider Not Eligible To Perform Service/Dispense Product	2Ø1-B1	
6Ø	Product/Service Not Covered For Patient Age	3Ø2, 3Ø4, 4Ø1, 4Ø7, 489-TE	
61	Product/Service Not Covered For Patient Gender	3Ø2, 3Ø5, 4Ø7, 489-TE	
62	Patient/Card Holder ID Name Mismatch	31Ø, 311, 312, 313, 3Ø2	
63	Institutionalized Patient Product/Service ID Not Covered		
64	Claim Submitted Does Not Match Prior Authorization	2Ø1, 4Ø4, 4Ø7, 442-E7, 461-EU, 462-EV, 489-TE	
65	Patient Is Not Covered	3Ø3, 3Ø6	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
66	Patient Age Exceeds Maximum Age	3Ø3, 3Ø4, 3Ø6	
67	Filled Before Coverage Effective	4Ø1	
68	Filled After Coverage Expired	4Ø1	
69	Filled After Coverage Terminated	4Ø1	
7A	Provider Does Not Match Authorization On File	2Ø1-B1	
7B	Service Provider ID Qualifier Value Not Supported For Processor/Payer	2Ø2-B2	
7C	M/I Other Payer ID	34Ø	
7D	Non-Matched DOB	3Ø4-C4	
7E	M/I DUR/PPS Code Counter	473	
7G	Future Date Not Allowed For DOB	3Ø4-C4	
7H	Non-Matched Gender Code	3Ø5-C5	
7J	Patient Relationship Code Not Supported	3Ø6-C6	
7K	Discrepancy Between Other Coverage Code And Other Payer Amt.,	3Ø8-C8	
7M	Discrepancy Between Other Coverage Code And Other Coverage Information On File	3Ø8-C8	
7N	Patient ID Qualifier Submitted Not Supported	331-CX	
7P	Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers	337-4C	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
7Q	Other Payer ID Qualifier Not Supported	339-6C	
7R	Other Payer Amount Paid Count Exceeds Number of Supported Groupings	341-HB	
7S	Other Payer Amount Paid Qualifier Not Supported	342-HC	
7T	Quantity Intended To Be Dispensed Required For Partial Fill Transaction	344-HF	
7U	Days Supply Intended To Be Dispensed Required For Partial Fill Transaction	345-HG	
7V	Duplicate Refills,	4Ø3-D3	
7W	Refills Exceed allowable Refills	4Ø3-D3	
7X	Days Supply Exceeds Plan Limitation	4Ø5-D5	
7Y	Compounds Not Covered,	4Ø6-D6	
7Z	Compound Requires Two Or More Ingredients,	4Ø6-D6	
7Ø	Product/Service Not Covered	4Ø7, 498	
71	Prescriber Is Not Covered	411	
72	Primary Prescriber Is Not Covered	421	
73	Refills Are Not Covered	4Ø2, 4Ø3	
74	Other Carrier Payment Meets Or Exceeds Payable	4Ø9, 442, 481-HA, 482-G3	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
75	Prior Authorization Required	462, 489-TE	
76	Plan Limitations Exceeded	4Ø5, 442	
77	Discontinued Product/Service ID Number	4Ø7, 489-TE	
78	Cost Exceeds Maximum	4Ø7, 4Ø9, 442, 448-ED, 449-EE, 481-HA, 482-G3, 489-TE	
79	Refill Too Soon	4Ø1, 4Ø3, 4Ø5	
8A	Compound Requires At Least One Covered Ingredient	4Ø6-D6	
8B	Compound Segment Missing On A Compound Claim	4Ø6-D6	
8C	M/I Facility ID	336	
8D	Compound Segment Present On A Non-Compound Claim	4Ø6-D6	
8E	M/I DUR/PPS Level Of Effort	474	
8G	Primary Product In A Compound Claim Is Not Zero	4Ø7-D7	
8H	Product/Service Only Covered On Compound Claim	4Ø7-D7	
8J	Incorrect Product/Service ID For Processor/Payer	4Ø7-D7, 489-TE	
8K	DAW Code Not Supported	4Ø8-D8	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
8M	Sum Of Compound Ingredient Costs Does Not Equal Ingredient Cost Submitted	4Ø9-D9	
8N	Future Date Prescription Written Not Allowed,	414-DE	
8P	Date Written Different On Previous Filling	414-DE	
8Q	Excessive Refills Authorized	415-DF	
8R	Submission Clarification Code Not Supported	42Ø-DK	
8S	Basis Of Cost Not Supported	423-DN	
8T	U&C Must Be Greater Than Zero	426-DQ	
8U	GAD Must Be Greater Than Zero	43Ø-DU	
8V	Negative Dollar Amount Is Not Supported In The Other Payer Amount Paid Field,	431-DV	
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid	431-DV	
8X	Collection From Cardholder Not Allowed,	433-DX	
8Y	Excessive Amount Collected	433-DX	
8Z	Product/Service ID Qualifier Value Not Supported	436-E1	
8Ø	Drug-Diagnosis Mismatch	4Ø7, 424	
81	Claim Too Old	4Ø1	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
82	Claim Is Post-Dated	4Ø1	
83	Duplicate Paid/Captured Claim	2Ø1, 4Ø1, 4Ø2, 4Ø3, 4Ø7	
84	Claim Has Not Been Paid/Captured	2Ø1, 4Ø1, 4Ø2	
85	Claim Not Processed	None	
86	Submit Manual Reversal	None	
87	Reversal Not Processed	None	
88	DUR Reject Error		
89	Rejected Claim Fees Paid		
9B	Reason For Service Code Value Not Supported	439-E4	
9C	Professional Service Code Value Not Supported	44Ø-E5	
9D	Result Of Service Code Value Not Supported	441-E6	
9E	Quantity Does Not Match Dispensing Unit	442-E7	
9G	Quantity Dispensed Exceeds Maximum Allowed,	442-E7	
9H	Quantity Not Valid For Product/Service ID Submitted	442-E7	
9J	Future Other Payer Date Not Allowed	443-E8	
9K	Compound Ingredient Component Count Exceeds Number Of Ingredients Supported	447-EC	
9M	Minimum Of Two Ingredients Required	447-EC	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
9N	Compound Ingredient Quantity Exceeds Maximum Allowed	448-ED	
9P	Compound Ingredient Drug Cost Must Be Greater Than Zero	449-EE	
9Q	Route Of Administration Submitted Not Covered	995-E2	
9R	Prescription/Service Reference Number Qualifier Submitted Not Covered	455-EM	
9S	Future Associated Prescription/Service Date Not Allowed	457-EP	
9T	Prior Authorization Type Code Submitted Not Covered	461-EU	
9U	Provider ID Qualifier Submitted Not Covered	465-EY	
9V	Prescriber ID Qualifier Submitted Not Covered	466-EZ	
9W	DUR/PPS Code Counter Exceeds Number Of Occurrences Supported	473-7E	
9X	Coupon Type Submitted Not Covered	485-KE	
9Y	Compound Product ID Qualifier Submitted Not Covered	488-RE	
9Z	Duplicate Product ID In Compound	489-TE	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
9Ø	Host Hung Up	Host Disconnected Before Session Completed	
91	Host Response Error	Response Not In Appropriate Format To Be Displayed	
92	System Unavailable/Host Unavailable	Processing Host Did Not Accept Transaction/Did Not Respond Within Time Out Period	
95	Time Out		
96	Scheduled Downtime		
97	Payer Unavailable		
98	Connection To Payer Is Down		
99	Host Processing Error	Do Not Retransmit Transaction(s)	
AA	Patient Spenddown Not Met		
AB	Date Written Is After Date Filled		
AC	Product Not Covered Non-Participating Manufacturer	489-TE, 4Ø7-D7	
AD	Billing Provider Not Eligible To Bill This Claim Type		
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare		

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
AF	Patient Enrolled Under Managed Care		
AG	Days Supply Limitation For Product/Service	489-TE, 4Ø7-D7	
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients		
AJ	Generic Drug Required	489-TE, 4Ø7-D7	
AK	M/I Software Vendor/Certification ID	11Ø	
AM	M/I Segment Identification	111	
AQ	M/I Facility Segment	111	
A5	Not Covered Under Part D Law		
A6	This Medication May Be Covered Under Part B		
A7	M/I Internal Control Number	993-A7	
A9	M/I Transaction Count	1Ø9	
BA	Compound Basis of Cost Determination Submitted Not Covered	49Ø-UE	
BB	Diagnosis Code Qualifier Submitted Not Covered	492-WE	
BC	Future Measurement Date Not Allowed	494-ZE	
BD	Sender Not Authorized To Submit File Type	7Ø2	
BE	M/I Professional Service Fee Submitted	477	
BF	M/I File Type	7Ø2	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
BG	Sender ID Not Certified For Processor/Payer	88Ø-K1	
BH	M/I Sender ID	88Ø-K1	
BJ	Transmission Type Submitted Not Supported,	88Ø-K6	
BK	M/I Transmission Type	88Ø-K6	
BM	M/I Narrative Message	39Ø	
B2	M/I Service Provider ID Qualifier	2Ø2	
CA	M/I Patient First Name	31Ø	
CB	M/I Patient Last Name	311	
CC	M/I Cardholder First Name	312	
CD	M/I Cardholder Last Name	313	
CE	M/I Home Plan	314	
CF	M/I Employer Name	315	
CG	M/I Employer Street Address	316	
CH	M/I Employer City Address	317	
CI	M/I Employer State/Province Address	318	
CJ	M/I Employer Zip Postal Zone	319	
CK	M/I Employer Phone Number	32Ø	
CL	M/I Employer Contact Name	321	
CM	M/I Patient Street Address	322	
CN	M/I Patient City Address	323	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
CO	M/I Patient State/Province Address	324	
CP	M/I Patient Zip/Postal Zone	325	
CQ	M/I Patient Phone Number	326	
CR	M/I Carrier ID	327	
CW	M/I Alternate ID	33Ø	
CX	M/I Patient ID Qualifier	331	
CY	M/I Patient ID	332	
CZ	M/I Employer ID	333	
DC	M/I Dispensing Fee Submitted	412	
DN	M/I Basis Of Cost Determination	423, 49Ø-UE	
DQ	M/I Usual And Customary Charge	426	
DR	M/I Prescriber Last Name	427	
DT	M/I Special Packaging Indicator	429	
DU	M/I Gross Amount Due	43Ø	
DV	M/I Other Payer Amount Paid	431	
DX	M/I Patient Paid Amount Submitted	433	
DY	M/I Date Of Injury	434	
DZ	M/I Claim/Reference ID	435	
EA	M/I Originally Prescribed Product/Service Code	445	
EB	M/I Originally Prescribed Quantity	446	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
EC	M/I Compound Ingredient Component Count	447	
ED	M/I Compound Ingredient Quantity	448	
EE	M/I Compound Ingredient Drug Cost	449	
EF	M/I Compound Dosage Form Description Code	45Ø	
EG	M/I Compound Dispensing Unit Form Indicator	451	
EJ	M/I Originally Prescribed Product/Service ID Qualifier	453	
EK	M/I Scheduled Prescription ID Number	454	
EM	M/I Prescription/Service Reference Number Qualifier	455	
EN	M/I Associated Prescription/Service Reference Number	456	
EP	M/I Associated Prescription/Service Date	457	
ER	M/I Procedure Modifier Code	459	
ET	M/I Quantity Prescribed	46Ø	
EU	M/I Prior Authorization Type Code	461	
EV	M/I Prior Authorization Number Submitted	462	
EW	M/I Intermediary Authorization Type ID	463	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
EX	M/I Intermediary Authorization ID	464	
EY	M/I Provider ID Qualifier	465	
EZ	M/I Prescriber ID Qualifier	466	
E1	M/I Product/Service ID Qualifier	436, 488-RE	
E2	M/I Route of Administration	995-E2	
E3	M/I Incentive Amount Submitted	438	
E4	M/I Reason For Service Code	439	
E5	M/I Professional Service Code	44Ø	
E6	M/I Result Of Service Code	441	
E7	M/I Quantity Dispensed	442	
E8	M/I Other Payer Date	443	
E9	M/I Provider ID	444	
FO	M/I Plan ID	524	
GE	M/I Percentage Sales Tax Amount Submitted	482	
G1	M/I Compound Type	996	
G2	M/I CMS Part D Defined Qualified Facility	997	
G4	Physician must contact plan		
G5	Pharmacist must contact plan		
G6	Pharmacy Not Contracted in Specialty Network		

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
G7	Pharmacy Not Contracted in Home Infusion Network		
G8	Pharmacy Not Contracted in Long Term Care Network		
G9	Pharmacy Not Contracted in 9Ø Day Retail Network (this message would be used when the pharmacy is not contracted to provide a 9Ø days supply of drugs)		
HA	M/I Flat Sales Tax Amount Submitted	481	
HB	M/I Other Payer Amount Paid Count	341	
HC	M/I Other Payer Amount Paid Qualifier	342	
HD	M/I Dispensing Status	343	
HE	M/I Percentage Sales Tax Rate Submitted	483	
HF	M/I Quantity Intended To Be Dispensed	344	
HG	M/I Days Supply Intended To Be Dispensed	345	
HN	M/I Patient E-Mail Address	35Ø	
H1	M/I Measurement Time	495	
H2	M/I Measurement Dimension	496	
H3	M/I Measurement Unit	497	
H4	M/I Measurement Value	499	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
H5	M/I Primary Care Provider Location Code	469	
H6	M/I DUR Co-Agent ID	476	
H7	M/I Other Amount Claimed Submitted Count	478	
H8	M/I Other Amount Claimed Submitted Qualifier	479	
H9	M/I Other Amount Claimed Submitted	48Ø	
JE	M/I Percentage Sales Tax Basis Submitted	484	
J9	M/I DUR Co-Agent ID Qualifier	475	
KE	M/I Coupon Type	485	
K5	M/I Transaction Reference Number	88Ø	
M1	Patient Not Covered In This Aid Category		
M2	Recipient Locked In		
M3	Host PA/MC Error		
M4	Prescription/Service Reference Number/Time Limit Exceeded		
M5	Requires Manual Claim		
M6	Host Eligibility Error		
M7	Host Drug File Error		
M8	Host Provider File Error		
ME	M/I Coupon Number	486	
MG	M/I Other Payer BIN Number	99Ø	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
MH	M/I Other Payer Processor Control Number	991	
MJ	M/I Other Payer Group ID	992	
MK	Non-Matched Other Payer BIN Number	99Ø	
MM	Non-Matched Other Payer Processor Control Number	991	
MN	Non-Matched Other Payer Group ID	992	
MP	Non-Matched Other Payer Cardholder ID	356	
MR	Drug Not on Formulary	4Ø7	
MS	More than 1 Cardholder Found – Narrow Search Criteria	3Ø2	
MT	M/I Patient Assignment Indicator (Direct Member Reimbursement Indicator)	391	
MU	M/I Benefit Stage Count	392	
MV	M/I Benefit Stage Qualifier	393	
MW	M/I Benefit Stage Amount	394	
MX	Benefit Stage Count Does Not Match Number Of Repetitions	392	
MY	M/I Address Count	6Ø3-MY	
MZ	Error Overflow		
NA	M/I Address Qualifier	6Ø4-NA	
NB	M/I Client Name	6Ø5-NB	
NC	M/I Discontinue Date Qualifier	6Ø6-NC	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
ND	M/I Discontinue Date	6Ø7-ND	
NE	M/I Coupon Value Amount	487	
NF	M/I Easy Open Cap Indicator	6Ø8-NF	
NG	M/I Effective Date	6Ø9-NG	
NH	M/I Expiration Date	61Ø-NH	
NJ	M/I File Structure Type	611-NJ	
NK	M/I Inactive Prescription Indicator	612-NK	
NM	M/I Label Directions	613-NM	
NN	Transaction Rejected At Switch Or Intermediary		
NP	M/I Other Payer-Patient Responsibility Amount Qualifier	351	
NQ	M/I Other Payer-Patient Responsibility Amount	352	
NR	M/I Other Payer-Patient Responsibility Amount Count	353	
NU	M/I Other Payer Cardholder ID	356	
NV	M/I Delay Reason Code	357	
NW	M/I Most Recent Date Filled	614-NW	
NX	M/I Submission Clarification Code Count	354	
NY	M/I Number Of Fills To-Date	615-NY	
N1	No patient match found.		
N3	M/I Medicaid Paid Amount	113	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
N4	M/I Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)	114	
N5	M/I Medicaid ID Number	115	
N6	M/I Medicaid Agency Number	116	
N7	Use Prior Authorization Code Provided During Transition Period		
N8	Use Prior Authorization Code Provided For Emergency Fill		
N9	Use Prior Authorization Code Provided For Level of Care Change		
PA	PA Exhausted/Not Renewable		
PB	Invalid Transaction Count For This Transaction Code	1Ø3, 1Ø9	
PC	M/I Request Claim Segment	111	
PD	M/I Request Clinical Segment	111	
PE	M/I Request Coordination Of Benefits/Other Payments Segment	111	
PF	M/I Request Compound Segment	111	
PG	M/I Request Coupon Segment	111	
PH	M/I Request DUR/PPS Segment	111	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
PJ	M/I Request Insurance Segment	111	
PK	M/I Request Patient Segment	111	
PM	M/I Request Pharmacy Provider Segment	111	
PN	M/I Request Prescriber Segment	111	
PP	M/I Request Pricing Segment	111	
PQ	M/I Narrative Segment	111	
PR	M/I Request Prior Authorization Segment	111	
PS	M/I Transaction Header Segment	111	
PT	M/I Request Worker's Compensation Segment	111	
PU	M/I Number Of Fills Remaining	616-PU	
PV	Non-Matched Associated Prescription/Service Date	457	
PW	Non-Matched Employer ID	333	
PX	Non-Matched Other Payer ID	34Ø	
PY	Non-Matched Unit Form/Route of Administration	451, 995, 6ØØ	
PZ	Non-Matched Unit Of Measure To Product/Service ID	4Ø7, 6ØØ	
PØ	Non-zero Value Required for Vaccine Administration	438	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
P1	Associated Prescription/Service Reference Number Not Found	456	
P2	Clinical Information Counter Out Of Sequence	493	
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions	447	
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions	337	
P5	Coupon Expired	486	
P6	Date Of Service Prior To Date Of Birth	3Ø4, 4Ø1	
P7	Diagnosis Code Count Does Not Match Number Of Repetitions	491	
P8	DUR/PPS Code Counter Out Of Sequence	473	
P9	Field Is Non-Repeatable		
RA	PA Reversal Out Of Order		
RB	Multiple Partials Not Allowed		
RC	Different Drug Entity Between Partial & Completion		
RD	Mismatched Cardholder/Group ID-Partial To Completion	3Ø1, 3Ø2	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
RE	M/I Compound Product ID Qualifier	488	Deleted in Telecom VB.Ø: Use Reject Code "E1"=M/I Product/Service ID Qualifier
RF	Improper Order Of 'Dispensing Status' Code On Partial Fill Transaction		
RG	M/I Associated Prescription/service Reference Number On Completion Transaction	456	
RH	M/I Associated Prescription/Service Date On Completion Transaction	457	
RJ	Associated Partial Fill Transaction Not On File		
RK	Partial Fill Transaction Not Supported		
RL	Transitional Benefit/Resubmit Claim		
RM	Completion Transaction Not Permitted With Same 'Date Of Service' As Partial Transaction	4Ø1	
RN	Plan Limits Exceeded On Intended Partial Fill Field Limitations	344, 345	
RP	Out Of Sequence 'P' Reversal On Partial Fill Transaction		
RQ	M/I Original Dispensed Date	617-RQ	
RR	M/I Patient ID Qualifier Count	618-RR	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
RS	M/I Associated Prescription/Service Date On Partial Transaction	457	
RT	M/I Associated Prescription/Service Reference Number On Partial Transaction	456	
RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment		
RV	Multiple Reversals Per Transmission Not Supported	1Ø9	
RW	M/I Prescribed Drug Description	619-RW	
RX	M/I Prescriber ID Count	62Ø-RX	
RY	M/I Prescriber Specialty	621-RY	
RZ	M/I Prescriber Specialty Count	622-RZ	
RØ	Professional Service Code Required For Vaccine Incentive Fee	44Ø	
R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions	478, 48Ø	
R2	Other Payer Reject Count Does Not Match Number Of Repetitions	471, 472	
R3	Procedure Modifier Code Count Does Not Match Number Of Repetitions	458, 459	
R4	Procedure Modifier Code Invalid For Product/Service ID	4Ø7, 436, 459	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals Ø6	4Ø7, 436	
R6	Product/Service Not Appropriate For This Location	3Ø7, 4Ø7, 436, 489-TE	
R7	Repeating Segment Not Allowed In Same Transaction		
R8	Syntax Error		
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae	43Ø	
SØ	Accumulator Month Count Does Not Match Number of Repetitions	656-S7	
S1	M/I Accumulator Year	65Ø-S1	
S2	M/I Transaction Identifier	651-S2	
S3	M/I Accumulated Patient True Out Of Pocket Amount	652-S3	
S4	M/I Accumulated Gross Covered Drug Cost Amount	653-S4	
S5	M/I DateTime	654-S5	
S6	M/I Accumulator Month	655-S6	
S7	M/I Accumulator Month Count	656-S7	
S8	Non-Matched Transaction Identifier	651-S2	
S9	M/I Financial Information Reporting Transaction Header Segment	111-AM	
SA	M/I Quantity Dispensed To Date	623-SA	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
SB	M/I Record Delimiter	624-SB	
SC	M/I Remaining Quantity	625-SC	
SD	M/I Sender Name	626-SD	
SE	M/I Procedure Modifier Code Count	458	
SF	Other Payer Amount Paid Count Does Not Match Number Of Repetitions	341	
SG	Submission Clarification Code Count Does Not Match Number of Repetitions	354	
SH	Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions	353	
SJ	M/I Total Number Of Sending And Receiving Pharmacy Records	63Ø-SJ	
SK	M/I Transfer Flag	631-SK	
SM	M/I Transfer Type	632-SM	
SN	M/I Package Acquisition Cost	633-SN	
SP	M/I Unique Record Identifier	634-SP	
SQ	M/I Unique Record Identifier Qualifier	635-SQ	
SW	Accumulated Patient True Out of Pocket must be equal to or greater than zero	652-S3	
TD	M/I Pharmacist Initials	636-TD	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
TE	Missing/Invalid Compound Product ID	489	Deleted Telecom VB.Ø Use Reject Code "21"=M/I Product/Service ID
TF	M/I Technician Initials	637-TF	
TG	Address Count Does Not Match Number Of Repetitions	6Ø3-MY	
TH	Patient ID Qualifier Count Does Not Match Number Of Repetitions	618-RR	
TJ	Prescriber ID Count Does Not Match Number Of Repetitions	62Ø-RX	
TK	Prescriber Specialty Count Does Not Match Number Of Repetitions	622-RZ	
TM	Telephone Number Count Does Not Match Number Of Repetitions	628-SG	
TN	Emergency Fill/Resubmit Claim		
TP	Level of Care Change/Resubmit Claim		
TQ	Dosage Exceeds Product Labeling Limit	442, 4Ø5	
TR	M/I Billing Entity Type Indicator	117	
TS	M/I Pay To Qualifier	118	
TT	M/I Pay To ID	119	
TU	M/I Pay To Name	12Ø	
TV	M/I Pay To Street Address	121	
TW	M/I Pay To City Address	122	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
TX	M/I Pay to State/ Province Address	123	
TY	M/I Pay To Zip/Postal Zone	124	
TZ	M/I Generic Equivalent Product ID Qualifier	125	
TØ	Accumulator Month Count Exceeds Number of Occurrences Supported	656-S7	
T1	Request Financial Segment Required For Financial Information Reporting	111-AM	
T2	M/I Request Reference Segment	111-AM	
T3	Out of Order DateTime	654-S5	
T4	Duplicate DateTime	654-S5	
UA	M/I Generic Equivalent Product ID	126	
UE	M/I Compound Ingredient Basis Of Cost Determination	49Ø	Deleted Telecom VB.Ø Use Reject Code "DN"=M/I Basis Of Cost Determination
UU	DAW Ø cannot be submitted on a multi-source drug with available generics.		
UZ	Other Payer Coverage Type (338-5C) required on reversals to downstream payers. Resubmit reversal with this field.	338	
UØ	M/I Sending Pharmacy ID	627-SF	
U7	M/I Pharmacy Service Type	147	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
VA	Pay To Qualifier Submitted Not Supported	118	
VB	Generic Equivalent Product ID Qualifier Submitted Not Supported	125	
VC	Pharmacy Service Type Submitted Not Supported	147	
VD	Eligibility Search Time Frame Exceeded		
VE	M/I Diagnosis Code Count	491	
VØ	M/I Telephone Number Count	628-SG	
WE	M/I Diagnosis Code Qualifier	492	
WØ	M/I Telephone Number Qualifier	629-SH	
W5	M/I Bed	671-W1	
W6	M/I Facility Unit	672-W2	
W7	M/I Hours of Administration	673-W3	
W8	M/I Room	674-W4	
W9	Accumulated Gross Covered Drug Cost Amount Must Be Equal To Or Greater Than Zero	653-S4	
XE	M/I Clinical Information Counter	493	
X1	Accumulated Patient True Out of Pocket exceeds maximum	652	
X2	Accumulated Gross Covered Drug Cost exceeds maximum	653	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
X3	Out of order Accumulator Months	656, 655	
X4	Accumulator Year not current or prior year	65Ø	
X5	M/I Financial Information Reporting Request Insurance Segment	111	
X6	M/I Request Financial Segment	111	
X7	Financial Information Reporting Request Insurance Segment Required For Financial Reporting	111	
X8	Procedure Modifier Code Count Exceeds Number Of Occurrences Supported	458-SE	
X9	Diagnosis Code Count Exceeds Number Of Occurrences Supported	491-VE	
YA	Compound Ingredient Modifier Code Count Exceeds Number Of Occurrences Supported	362-2G	
YB	Other Amount Claimed Submitted Count Exceeds Number Of Occurrences Supported	478-H7	
YC	Other Payer Reject Count Exceeds Number Of Occurrences Supported	471-5E	
YD	Other Payer-Patient Responsibility Amount Count Exceeds Number Of Occurrences Supported	353-NR	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
YE	Submission Clarification Code Count Exceeds Number of Occurrences Supported	354-NX	
YF	Question Number/Letter Count Exceeds Number Of Occurrences Supported	377-2Z	
YG	Benefit Stage Count Exceeds Number Of Occurrences Supported	392-MU	

REJECT CODES FOR TELECOMMUNICATION STANDARD			
Reject Code	**Explanation**	**Field # Possibly In Error**	**Field Limitation**
YH	Clinical Information Counter Exceeds Number of Occurrences Supported	493-XE	
YJ	Non-Matched Medicaid Agency Number	116-N6	
ZA	The Coordination of Benefits/Other Payments Segment is mandatory to a downstream payer.		
ZE	M/I Measurement Date	494	

2. FORMULARY AND BENEFIT REJECT CODES

Reject Code	Explanation	Field Possibly in Error or Example
1ØØ1	Required segment missing	
1ØØ2	Required list missing	Only a file header FDR and trailer TRL are present. No lists are present.
1ØØ3	Unknown segment	There is an extra blank line in the file.
1ØØ4	Unexpected segment	A record is out of order or doesn't have a valid record identifier.
1ØØ5	Failed to parse embedded list	The list type field in a list header is not valid. Coverage list type is TS instead of TM.
1ØØ6	Required field missing	
1ØØ7	Invalid field length	
1ØØ8	Field value not found in validation table	Valid values are 1,2,3 and a value of 4 is found.
1ØØ9	Invalid character(s) in field	A space character is in a numeric field.
1Ø1Ø	Extra data found after segment	
1Ø11	Effective date processing error	The date sent is in the correct format but not valid considering the other effective dates of lists published.
1Ø12	Invalid Record Count	The file or list trailer has the wrong value in the record count field.
1Ø13	Invalid Sender/Receiver Id or Password	
9ØØØ	Other Error	Error is not one of the codes, see free text for description.

B. APPENDIX B – REFERENCE CODES

1. PRODUCT/SERVICE QUALIFIER

Key: (See table below for value definitions)

X	=	Value is applicable for use in field
Blank	=	Value may not be used in field

NAME OF VALUE	VALUES	PRODUCT/SERVICE ID QUALIFIER (436-E1)	COMPOUND PRODUCT ID QUALIFIER (488-RE)	DUR CO-AGENT ID QUALIFIER (475-J9)	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER (453-EJ)	PREFERRED PRODUCT ID QUALIFIER (552-AP)	PRODUCT/SERVICE ID QUALIFIER - ALTERNATIVE (959-HV)	PRODUCT/SERVICE ID QUALIFIER – STEP DRUG (961-HX)	PRODUCT/SERVICE ID QUALIFIER - SOURCE (963-HZ)	GENERIC EQUIVALENT PRODUCT ID QUALIFIER (125-TZ)	COMMENTS
Not Specified	Blank	X	X	X	X	X					Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted for use in higher versions of these standards.
Not Specified	ØØ	X			X						Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted for use in higher versions of these standards.
Universal Product Code (UPC)	Ø1	X	X	X	X	X	X	X	X	X	Formatted 11 digits (N)
Health Related Item (HRI)	Ø2	X	X	X	X	X	X	X	X	X	Formatted 11 digits (N)
National Drug Code (NDC)	Ø3	X	X	X	X	X	X	X	X	X	NCPDP Formatted 11 digits (N)

NAME OF VALUE	VALUES	PRODUCT/SERVICE ID QUALIFIER (436-E1)	COMPOUND PRODUCT ID QUALIFIER (488-RE)	DUR CO-AGENT ID QUALIFIER (475-J9)	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER (453-EJ)	PREFERRED PRODUCT ID QUALIFIER (552-AP)	PRODUCT/SERVICE ID QUALIFIER - ALTERNATIVE (959-HV)	PRODUCT/SERVICE ID QUALIFIER – STEP DRUG (961-HX)	PRODUCT/SERVICE ID QUALIFIER - SOURCE (963-HZ)	GENERIC EQUIVALENT PRODUCT ID QUALIFIER (125-TZ)	COMMENTS
Health Industry Business Communications Council (HIBCC)	Ø4	X	X	X	X	X	X	X	X	X	Variable A/N
Department of Defense (DOD)	Ø5	X	X	X	x	x	X	X	X		This value was deleted in the publication of the July 2ØØ7 ECL and should not be used by any of the standards from that date forward.
Drug Use Review/ Professional Pharmacy Service (DUR/PPS)	Ø6	X			X		X	X	X	X	
Common Procedure Terminology (CPT4)	Ø7	X		X	X		X	X	X	X	5 character (A/N)
Common Procedure Terminology (CPT5)	Ø8	X		X	X		X	X	X	X	5 character (A/N)
Health Care Financing Administration Common Procedural Coding System (HCPCS)	Ø9	X		X	X		X	X	X	X	5 character (A/N)
Pharmacy Practice Activity Classification (PPAC)	1Ø	X			X		X	X	X	X	
National Pharmaceutical Product Interface Code (NAPPI)	11	X	X	X	X	X	X	X	X	X	South African Code

NAME OF VALUE	VALUES	PRODUCT/SERVICE ID QUALIFIER (436-E1)	COMPOUND PRODUCT ID QUALIFIER (488-RE)	DUR CO-AGENT ID QUALIFIER (475-J9)	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER (453-EJ)	PREFERRED PRODUCT ID QUALIFIER (552-AP)	PRODUCT/SERVICE ID QUALIFIER - ALTERNATIVE (959-HV)	PRODUCT/SERVICE ID QUALIFIER – STEP DRUG (961-HX)	PRODUCT/SERVICE ID QUALIFIER - SOURCE (963-HZ)	GENERIC EQUIVALENT PRODUCT ID QUALIFIER (125-TZ)	COMMENTS
Global Trade Identification Number (GTIN)	12	X	X	X	X	X	X	X	X	X	14 digits (N) – UCC Standard (UPN)
Drug Identification Number (DIN)	13	X	X	X	X	X	X	X	X		This value was deleted in the publication of the July 2ØØ7 ECL and should not be used by any of the standards from that date forward.
Medi-Span Product Line Generic Product Identifier (GPI)	14			X		X					
First DataBank Formulation ID (GCN)	15	X	X	X	X	X	X	X	X	X	
Micromedex/Medical Economics Generic Formulation Code (GFC)	16			X		X					
Medi-Span Product Line Drug Descriptor ID (DDID)	17			X		X					
First DataBank SmartKey	18			X		X					
Micromedex/Medical Economics Generic Master (GM)	19			X		X					
International Classification of Diseases (ICD9)	2Ø			X							

Name of Value	Values	Product/Service ID Qualifier (436-E1)	Compound Product ID Qualifier (488-RE)	DUR Co-Agent ID Qualifier (475-J9)	Originally Prescribed Product/Service ID Qualifier (453-EJ)	Preferred Product ID Qualifier (552-AP)	Product/Service ID Qualifier - Alternative (959-HV)	Product/Service ID Qualifier – Step Drug (961-HX)	Product/Service ID Qualifier - Source (963-HZ)	Generic Equivalent Product ID Qualifier (125-TZ)	Comments
International Classification of Diseases-1Ø-Clinical Modifications (ICD-1Ø-CM)	21			X							
Medi-Span Product Line Diagnosis Code	22			X							
National Criteria Care Institute (NCCI)	23			X							
The Systematized Nomenclature of Human and Veterinary Medicine (SNOMED)	24			X							
Common Dental Terminology (CDT)	25			X							
American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)	26			X							
International Classification of Diseases-1Ø-Procedure Coding System (ICD-1Ø-PCS)	27			X							

NAME OF VALUE	VALUES	PRODUCT/SERVICE ID QUALIFIER (436-E1)	COMPOUND PRODUCT ID QUALIFIER (488-RE)	DUR CO-AGENT ID QUALIFIER (475-J9)	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER (453-EJ)	PREFERRED PRODUCT ID QUALIFIER (552-AP)	PRODUCT/SERVICE ID QUALIFIER - ALTERNATIVE (959-HV)	PRODUCT/SERVICE ID QUALIFIER – STEP DRUG (961-HX)	PRODUCT/SERVICE ID QUALIFIER - SOURCE (963-HZ)	GENERIC EQUIVALENT PRODUCT ID QUALIFIER (125-TZ)	COMMENTS
First DataBank Medication Name ID (FDB Med Name ID)	28	X	X	X	X	X	X	X	X	X	
First DataBank Routed Medication ID (FDB Routed Med ID)	29	X	X	X	X	X	X	X	X	X	
First DataBank Routed Dosage Form ID (FDB Routed Dosage Form Med ID)	3Ø	X	X	X	X	X	X	X	X	X	
First DataBank Medication ID (FDB MedID)	31	X	X	X	X	X	X	X	X	X	
First DataBank Clinical Formulation ID Sequence Number (GCN_SEQ_NO)	32	X	X	X	X	X	X	X	X	X	
First DataBank Ingredient List ID (HICL_SEQ_NO)	33	X	X	X	X	X	X	X	X	X	
Universal Product Number (UPN)	34	X					X	X	X	X	
Logical Observation Identifier Names and Codes (LOINC)	35			X							Code set used to report laboratory and clinical observations.

NAME OF VALUE	VALUES	PRODUCT/SERVICE ID QUALIFIER (436-E1)	COMPOUND PRODUCT ID QUALIFIER (488-RE)	DUR CO-AGENT ID QUALIFIER (475-J9)	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER (453-EJ)	PREFERRED PRODUCT ID QUALIFIER (552-AP)	PRODUCT/SERVICE ID QUALIFIER - ALTERNATIVE (959-HV)	PRODUCT/SERVICE ID QUALIFIER – STEP DRUG (961-HX)	PRODUCT/SERVICE ID QUALIFIER - SOURCE (963-HZ)	GENERIC EQUIVALENT PRODUCT ID QUALIFIER (125-TZ)	COMMENTS
Representative National Drug Code (NDC)	36	X					X	X	X		
Other	99	X	X	X	X	X	X	X	X	X	

Name of Value	Definition
Universal Product Code (UPC)	**An 11digit code which identifies the manufacturer and the specific description of the product.**
Health Related Item (HRI)	**Health Related Item is a unique 1Ø digit numeric code assigned to health related drug products by the FDA and the manufacturer or distributor. The format of an HRI is 4-6 and it is converted to the 11 digit number used on billing transactions by adding a zero to the 11th position.**
National Drug Code	**National Drug Code is a unique 1Ø-digit, 3-segment number, assigned to each drug product by the FDA. For consistency in billing and reimbursement in the pharmacy services sector of healthcare, the NDC in a unique 11 digit formatted number, a zero is added. This number identifies the labeler/manufacturer, product, and package size of the drug. The first segment is the labeler code and assigned by the FDA. The second segment, the product code, identifies a specific strength, dosage form, and formulation. The third segment, the package code, identifies package sizes. Both the product and package codes are assigned by the labeler/manufacturer.**
Health Industry Business Communication Council (HIBCC)	**A 9-digit alphanumeric number used to identify health care entities such as veterinarians, animal clinics, and health care provider facilities.**
Drug Use Review/Professional Pharmacy Service (DUR/PPS)	**Cognitive service involving the concurrent or prospective review of therapeutic regimens for the purpose of improving outcome, preventing adverse sequela and/or assisting patients in understanding the content and purpose of drug therapy.**
Current Procedural Terminology (CPT 4)	**Code indicating that the following data is a CPT® code. Current Procedural Terminology (CPT®) Fourth Edition is a listing of descriptive terms and identifying codes for reporting medical services and procedures. The code set is managed by the CPT Editorial panel and is maintained and published by the American Medical Association. Also known as Healthcare Common Procedure System (HCPCS) Level I.**
Current Procedural Terminology (CPT5)	**Enhancements to CPT® 4 in development with emphasis on maintaining what works while correcting problems and extending the applicability of CPT into new areas.**
Health Care Financing Administration Common Procedural Coding System (HCPCS)	**The Healthcare Common Procedure Coding System (HCPCS) is a uniform method for health care providers and medical suppliers to report professional services, procedures and supplies. Used specifically it applies to the Level II Alpha codes (a letter followed by 4 numerals) and modifiers. Used generically HCPCS includes the Level I CPT procedure codes and modifiers. HCPCS Level II codes are maintained and published by the Centers for Medicare and Medicaid Services (CMS). Level III - Local Codes eliminated by HIPAA effective 1Ø/16/Ø3.**
Pharmacy Practice Activity Classification (PPAC)	**A classification system or taxonomy to evaluate research on the pharmaceutical care activities performed by pharmacists and to provide valid, measurable units of pharmacist contributions to patient health. These then become the basis for documentation and billing.**
National Pharmaceutical Product	**A unique identifier for a given product which enables electronic transfer of information throughout the South African healthcare delivery**

Name of Value	Definition
Interface Code (NAPPI)	**chain. NAPPI as a coding standard that contains information on the NAPPI code, product description, strength, pack size and manufacturer.**
Global Trade Identification Number (GTIN)	**The foundation for the EAN.UCC System for uniquely identifying trade items (products and services) sold, delivered, warehoused, and billed throughout the retail and commercial distribution channels. It provides an accurate, efficient and economical means of controlling the flow of products and information through the use of an all-numeric identification system.**
Medi-Span Product Line Generic Product Identifier (GPI)	**A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration.**
First DataBank Formulation ID (GCN)	**A six-character numeric indicator that represents a generic drug formulation identifier that groups together drug products by the following criteria: Ingredients List Identifier (HICL_SEQNO) which represents the list or set of ingredients in a drug formulation; Route of Administration; Dosage Form; Strength of Drug. A unique GCN_SEQNO is assigned to each different combination of ingredient(s), strength, dosage form, and route of administration for a generic drug formulation.**
Micromedex/Medical Economics Generic Formulation Code (GFC)	**The Generic Formulation Code (GFC) serves as the key that links all of the UltiMedex clinical modules. The GFC represents a group of products sharing the same active ingredients, route, form, and strength.**
Medi-Span Product Line Drug Descriptor ID (DDID)	**Proprietary code used by Medi-Span product line to specify diagnosis.**
First DataBank SmartKey	**24-character element that defines a product by therapeutic class, ingredients, strength, dosage form, route and certain packaging. characteristics.**
Micromedex/Medical Economics Generic Master (GM)	**Unique and persistent identifier for the core or base ingredient of a drug.**
International Classification of Diseases (ICD9)	**Code indicating the diagnosis is defined according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. Most codes are numeric and consist of 3, 4, or 5 numbers and a description. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services.**
International Classification of Diseases-1Ø-Clinical Modifications (ICD-1Ø-CM)	**Code indicating that the following information is a diagnosis as defined by ICD-1Ø-CM. As of January 1, 1999, the ICD-1Ø is used to code and classify mortality data from death certificates. The International Classification of Diseases, 1Øth Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. The codes are 3 to 7 digits with the first digit alpha, the second and third numeric and the remainder A/N. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services.**
Medi-Span Product Line Diagnosis Code	**Proprietary code used by Medi-Span product line to specify diagnosis**
National Criteria Care Institute (NCCI)	**The CMS-developed Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.**
The Systematized Nomenclature of Human and Veterinary Medicine (SNOMED)	**A clinical health care terminology and infrastructure that provides a common language that enables a consistent way of capturing, sharing and aggregating health data across specialties and sites of care.**
Common Dental Terminology (CDT)	**Current Dental Terminology (CDT) is the published Code on Dental Procedures and Nomenclature (the Code) providing descriptive terms, codes and guidance for the accurate reporting of dental procedures. The Code is maintained by the Code Revision Committee and published by the American Dental Association. The procedure codes and descriptions are also published as part of the Healthcare Common Procedure System (HCPCS) Level II through agreement with Centers for Medicare and Medicaid Services.**
American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)	**Diagnostic criteria for the most common mental disorders including: description, diagnosis, treatment, and research findings. Comments: The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV) is published by the American Psychiatric Association, Washington D.C.**

Name of Value	Definition
International Classification of Diseases-1Ø-Procedure Coding System (ICD-1Ø-PCS)	**Multi-axial seven-character alphanumeric code structure developed by CMS that provides a unique code for all substantially different procedures, and allows new procedures to be easily incorporated as new codes. This code set replace Volume 3 of the International Classification of Diseases 9th Revision (ICD-9-CM)**
First DataBank Medication Name ID (FDB Med Name ID)	**A permanent numeric identifier that represents a unique product or generic name.**
First DataBank Routed Medication ID (FDB Routed Med ID)	**Represents the product or generic name and route of administration.**
First DataBank Routed Dosage Form ID (FDB Routed Dosage Form Med ID)	**Represents the product or generic name, route of administration, and dosage form.**
First DataBank Medication ID (FDB MedID)	**A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure.**
First DataBank Clinical Formulation ID Sequence Number (GCN_SEQ_NO)	**A six-character numeric indicator that represents a generic drug formulation identifier that groups together drug products by the following criteria: Ingredients List Identifier (HICL_SEQNO) which represents the list or set of ingredients in a drug formulation; Route of Administration; Dosage Form; Strength of Drug. A unique GCN_SEQNO is assigned to each different combination of ingredient(s), strength, dosage form, and route of administration for a generic drug formulation.**
First DataBank Ingredient List ID (HICL_SEQ_NO)	**A six-character numeric indicator that identifies a unique combination of active ingredients, irrespective of the manufacturer, package size, dosage form, route of administration, or strength.**
Universal Product Number (UPN)	**Unambiguously identifies medical/surgical products in the supply chain, thereby simplifying product distribution. Each product, at all levels of packaging, will be assigned a unique UPN, consisting of either the HIBC-LIC or UCC/EAN primary data structure.**
Representative National Drug Code (NDC)	**An 11-digit NDC code that depicts a category of medication exclusive of package size and manufacturer/labeler. A representative NDC should not be a repackaged NDC, obsolete NDC, private label NDC or unit dose NDC unless it is the only NDC available identifying that category of medication.**

2. DRUG REFERENCE VALUES

Key: (See table below for value definitions)

X	=	Value is applicable for use in field
Blank	=	Value may not be used in field

NAME OF VALUE	VALUES	DRUG REFERENCE QUALIFIER (916-B7)	DRUG REFERENCE QUALIFIER-ALTERNATIVE (918-B9)	DRUG REFERENCE QUALIFIER-SOURCE (92Ø-CT)	DRUG REFERENCE QUALIFIER-STEP DRUG (922-CV)	SCRIPT	REFERENCE QUALIFIER–GENERIC DATABASE, PRIOR AUTHORIZATION - DRU SEGMENT (1153)	COMMENTS
Not Specified	Blank							
Medical Economics Generic Formulation Code (GFC)	E	X	X	X	X		X	
Medical Economics Generic Master (GM)	G	X	X	X	X		X	
American Hospital Formulary Service (AHFS)	AF	X	X	X	X			
First DataBank Routed Dosage Form ID (FDB Routed Dosage Form Med ID)	FD	X	X	X	X		X	
First DataBank Clinical Formulation ID Sequence Number (GCN_SEQ_NO)	FG	X	X	X	X		X	
First DataBank Medication ID (FDB MedID)	FI						X	
First DataBank Ingredient List ID (HICL_SEQ_NO)	FL						X	
First DataBank Medication ID (FDB MedID)	FM	X	X	X	X		X	
First DataBank Medication Name ID (FDB Med Name ID)	FN	X	X	X	X		X	
First DataBank Routed Medication ID (FDB Routed Med ID)	FR	X	X	X	X			
First Databank Smartkey	FS	X	X	X	X		X	
Gold Standard Product Item Collection	GS	X	X	X	X			
Multum Drug ID	MC	X	X	X	X		X	
Medi-Span Product Line (DDID)	MD	X	X	X	X		X	
Medi-Span Generic Product Identifier (GPI)	MG	X	X	X	X		X	
Multum MMDC	MM	X	X	X	X		X	

NAME OF VALUE	VALUES	DRUG REFERENCE QUALIFIER (916-B7)	DRUG REFERENCE QUALIFIER-ALTERNATIVE (918-B9)	DRUG REFERENCE QUALIFIER-SOURCE (92Ø-CT)	DRUG REFERENCE QUALIFIER-STEP DRUG (922-CV)	SCRIPT	REFERENCE QUALIFIER–GENERIC DATABASE, PRIOR AUTHORIZATION - DRU SEGMENT (1153)	COMMENTS
U.S. Pharmacopoeia (USP)	US	X	X	X	X			

Name of Value	Definition
Medical Economics Generic Formulation Code (GFC)	**The Generic Formulation Code (GFC) serves as the key that links all of the UltiMedex clinical modules. The GFC represents a group of products sharing the same active ingredients, route, form, and strength.**
Medical Economics Generic Master (GM)	**Unique and persistent identifier for the core or base ingredient of a drug.**
American Hospital Formulary Service (AHFS)	**Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations, chemistry, and stability; pharmacology and pharmacokinetics; contraindications.**
First DataBank Routed Dosage Form ID (FDB Routed Dosage Form Med ID)	**Represents the product or generic name, route of administration, and dosage form.**
First DataBank Clinical Formulation ID Sequence Number (GCN_SEQ_NO)	**A six-character numeric indicator that represents a generic drug formulation identifier that groups together drug products by the following criteria: Ingredients List Identifier (HICL_SEQNO) which represents the list or set of ingredients in a drug formulation; Route of Administration; Dosage Form; Strength of Drug. A unique GCN_SEQNO is assigned to each different combination of ingredient(s), strength, dosage form, and route of administration for a generic drug formulation.**
First DataBank Medication ID (FDB MedID)	**A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure.**
First DataBank Ingredient List ID (HICL_SEQ_NO)	**A six-character numeric indicator that identifies a unique combination of active ingredients, irrespective of the manufacturer, package size, dosage form, route of administration, or strength.**
First DataBank Medication ID (FDB MedID)	**A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure.**
First DataBank Medication Name ID (FDB Med Name ID)	**A permanent numeric identifier that represents a unique product or generic name.**
First DataBank Routed Medication ID (FDB Routed Med ID)	**Represents the product or generic name and route of administration.**

Name of Value	Definition
First Databank Smartkey	**24 character element that defines a product by therapeutic class, ingredients, strength, dosage form, route and certain packaging characteristics.**
Gold Standard Product Item Collection	**A long integer value that represents the unique collection of drug and non-drug items contained within at least one marketed product in the US. It serves as a link to all drug and non-drug items that are contained within a single dose form product, multi-dose form product, or kit containing one more drug and non-drug items. The identifier describes the ingredient formulation, strength(s) and dosage form of each drug item in a product, along with any non-drug items, such as syringes, needles, etc. and is independent of marketer or manufacturer, and serves as a unique identifier for all products sharing identical drug and/or non-drug items as they are marketed in the US.**
Multum Drug ID	**Corresponds to the generic name of a drug; links products to clinical information for drug use review messaging with respect to pregnancy risk categories, maximum number of therapeutic duplications allowed, half-life and an indicator whether the drug ID represents a single-ingredient product or a combination product.**
Medi-Span Product Line (DDID)	**Index terms and phrases assigned to each record to characterize the substantive content of the original drug.**
Medi-Span Generic Product Identifier (GPI)	**A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration.**
Multum (MMDC)	**Groups of drug products that share the same ingredient(s), strength, route and dose form.**
U.S. Pharmacopoeia (USP)	**The official public standards-setting authority for all prescription and over-the-counter medicines, dietary supplements, and other healthcare products manufactured and sold in the United States.**

C. APPENDIX C - UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS

STATES

State Code	State/Territory	NCPDP State Code
AL	Alabama	Ø1
AK	Alaska	Ø2
AZ	Arizona	Ø3
AR	Arkansas	Ø4
AS	American Samoa	
CA	California *(see Additional State Code)	Ø5
CO	Colorado	Ø6
CT	Connecticut	Ø7
DE	Delaware	Ø8
DC	District Of Columbia	Ø9
FM	Federated States Of Micronesia	
FL	Florida *(see Additional State Code)	1Ø
GA	Georgia	11
GU	Guam	54
HI	Hawaii	12
ID	Idaho	13
IL	Illinois	14
IN	Indiana	15
IA	Iowa	16
KS	Kansas	17
KY	Kentucky	18
LA	Louisiana	19
ME	Maine	2Ø
MH	Marshall Islands	
MD	Maryland	21
MA	Massachusetts	22
MI	Michigan	23
MN	Minnesota	24
MS	Mississippi	25

State Code	State/Territory	NCPDP State Code
MO	Missouri	26
MT	Montana	27
NE	Nebraska	28
NV	Nevada	29
NH	New Hampshire	3Ø
NJ	New Jersey	31
NM	New Mexico	32
NY	New York *(see Additional State Code)	33
NC	North Carolina	34
ND	North Dakota	35
MP	Northern Mariana Islands	
OH	Ohio	36
OK	Oklahoma	37
OR	Oregon	38
PW	Palau	
PA	Pennsylvania	39
PR	Puerto Rico	4Ø
RI	Rhode Island	41
SC	South Carolina	42
SD	South Dakota	43
TN	Tennessee	44
TX	Texas *(see Additional State Code)	45
UT	Utah	46
VT	Vermont	47
VA	Virginia	48
VI	Virgin Islands	53
WA	Washington	49
WV	West Virginia	5Ø
WI	Wisconsin	51
WY	Wyoming	52

***Additional State Codes for NCPDP Provider Identification Number**

State Code	State/Territory	Additional NCPDP State Code
CA	California	56
FL	Florida	57
NY	New York	58
TX	Texas	59

CANADA		
State Code	**Province**	
AB	Alberta	
BC	British Columbia	
MB	Manitoba	
NB	New Brunswick	
NF	Newfoundland	
NS	Nova Scotia	
NT	Northwest Territories	
NU	Nunayut	
ON	Ontario	
PE	Prince Edward Island	
QC	Quebec	
SK	Saskatchewan	
YT	Yukon	

D. APPENDIX D – RECONCILIATION REASON CODES FOR HEADER AND TRAILER RECORDS

Key:

T	=	Technical Reconciliation Reason Code
B	=	Business Reconciliation Reason Code

CODE	T/B	DESCRIPTION	DEFINITION	Header	Trailer
HØ1	T	Missing/Invalid Record Type	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-Ø4.	✓	✓
HØ2	T	Missing/Invalid FF Action Code	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-36.	✓	✓
HØ3	T	Missing/Invalid Rebate Version Release No.	Either the value for the mandatory field is missing or it does not match the mandatory value of 'Ø1.Ø1'.	✓	✓
HØ4	T	Missing/Invalid Transmission Date	Either the value for the mandatory field is missing or it does not match the valid date format of CCYYMMDD or it is not a valid date.	✓	✓
HØ5	T	Duplicate Transmission Control Number	This batch duplicates another earlier transmission. This does not apply when the Transmission Control Number is left blank.	✓	✓
HØ6	T	Missing Rebate Batch Number	The value for this mandatory field is missing.	✓	✓
HØ7	T	Missing/Invalid Rebate Period Start Date	Either the value for the mandatory field is missing or it does not match the valid date format of CCYYMMDD.	✓	✓
HØ8	T	Missing/Invalid Rebate Period End Date	Either the value for the mandatory field is missing or it does not match the valid date format of CCYYMMDD.	✓	✓
HØ9	B	Rebate Period Outside of Contract	This code shows that the Rebate Period Start Date or the Rebate Period End Date or both are outside the effective or the expiration dates of the contract.	✓	
H1Ø	B	Rebate Period Start or End Date not valid	Used when the submitted Rebate Period Start Date and/or Rebate Period End Date does not match up to the expected periods of the contract.	✓	
H11	T	Missing/Invalid FF Contracting Organization (PMO) ID Qualifier	Either the value for the mandatory field is missing or it does not match the field values list for field 6ØØ-71.	✓	✓
H12	T	Missing/Invalid FF Data Provider ID Qualifier	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-37.	✓	✓
H13	T	Missing/Invalid FF Manufacturer (PICO) ID Qualifier	Either the value for the mandatory field is missing or it does not match the field values list for field 6ØØ-72.	✓	✓
H14	B	Data not summarized at agreed level	Data is expected at one summarization but is provided at a different summarization. Refer to Data Level, field 6Ø1-31 for more information.	✓	
H15	B	Missing Products From Market Basket	Data for all products on the contract has not been provided.	✓	
H99	B	Other	Any time this code is used, a description of the error must be provided in the Reconciliation Error Description field.	✓	

CODE	T/B	DESCRIPTION	DEFINITION	Header	Trailer
HZ_	B	Reserved range for trading partner codes	HZ_ is reserved for codes to be defined between trading partners. Valid values for the third character are: Ø-9, A-Z	✓	
T51	T	Missing/Invalid Grand Total Metric Decimal Quantity	Either the value for the field is missing or is not a numeric for field 6Ø1-41.		✓
T52	T	Missing/Invalid Grand Total Requested Rebate Amount	Either the value for the field is missing or is not a numeric for field 6Ø1-42.		✓
T53	T	Missing/Invalid Total Record Count	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-Ø9.		✓
T54	B	Incorrect Grand Total Metric Decimal Quantity	When supplied, the total of the Total Metric Decimal Quantity fields on the Utilization Detail (UD) records does not add to the value supplied in the Trailer Record (TR).		✓
T55	B	Incorrect Grand Total Requested Rebate Amount	When supplied, the total of the Total Requested Rebate Amount fields on the Utilization Detail (UD) records does not add to the value supplied in the Trailer Record (TR).		✓
T56	B	Incorrect Total Record Count	The value supplied does not match the actual count of all records including the Header, Trailer, and all associated Utilization Detail (UD) records.		✓
T99	B	Other	Any time this code is used, a description of the error must be provided in the Reconciliation Error Description field.		✓
TZ_	B	Reserved range for trading partner codes	TZ_ is reserved for codes to be defined between trading partners. Valid values for the third character are: Ø-9, A-Z		✓

E. APPENDIX E – RECONCILIATION REASON CODES FOR DETAIL AND REBATE RECORDS

Key:

T	=	Technical Reconciliation Reason Code
B	=	Business Reconciliation Reason Code

These values used in Manufacturer Rebates Standard Version Ø4.Ø1 or greater but not in lower versions.

CODE	T/B	DESCRIPTION	DEFINITION
RØ1	T	Missing/Invalid Record Type	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-Ø4.
RØ2	T	Missing/Invalid Line Number	A value has not been provided for the Line Number field (6Ø1-43).
RØ3	T	Duplicate Line Number	Within one transmission or batch, the Line Number field has been duplicated. (Applies only when the optional Line Number field is being filled.)
RØ4	T	Missing/Invalid Data Level	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-31.
RØ5	T	Missing/Invalid Plan ID Qualifier	Either the value for the mandatory field is missing or it does not match the field values list for field 6ØØ-95.
RØ6	B	Missing Plan ID Code	A value for the field 6ØØ-94 is missing.
RØ7	T	Missing/Invalid Pharmacy ID Qualifier	Either the value for the mandatory field is missing or it does not match the field values list for field Service Provider ID Qualifier (2Ø2-B2).
RØ8	B	Missing Pharmacy ID	A value for the field Service Provider ID (2Ø1-B1) is missing.
RØ9	T	Missing/Invalid Product Qualifier	Either the value for the mandatory field is missing or it does not match the field values list for field 436-E1.
R1Ø	B	Missing Product ID	A value for the field 4Ø7-D7 is missing.
R11	B	Missing/Invalid DAW/Product Selection	Either the value for the mandatory field is missing or it does not match the field values for field 4Ø8-Ø8.
R12	T	Missing/Invalid Total Quantity	Either the value for the field is missing or is not a numeric for field 6Ø1-39.
R13	B	Missing/Invalid Unit of Measure	Either the value for the field is missing or it does not match the field values list for field 6ØØ-28.
R14	B	Missing/Invalid Dosage Form ID Code	Either the value for the field is missing or it does not match the field values list for field 6Ø1-34.
R15	B	Missing/Invalid Diagnosis Code	Either the value for the field is missing or it does not match valid ICD-9 codes for field 6ØØ-28.
R16	B	Missing/Invalid Prescription Type	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-49. (Applies only when Data Level is CP or PP.)
R17	B	Missing/Invalid Total Number of Prescriptions	Either the value for the field is missing or is not a numeric for field 6Ø1-4Ø.
R18	T	Missing/Invalid Date Filled/Date of Service	Either the value for the field is missing or it does not match the valid date format of CCYYMMDD. (Applies only when Data Level is CP or PP.)
R19	T	Missing/Invalid Therapeutic Class Code Qualifier	Either the value for the field is missing or it does not match the field values list for field 6Ø1-26.

CODE	T/B	DESCRIPTION	DEFINITION
R2Ø	T	Missing/Invalid Reimbursement Qualifier	Either the value for the field is missing or it does not match the field values list for field 6Ø1-48.
R21	B	Missing/Invalid Fill Number	Either the value for the field is missing or it does not match the field values list for field 4Ø3-D3.
R22	T	Missing/Invalid Record Purpose Indicator	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-53.
R23	T	Missing/Invalid Prescriber ID Qualifier	Either the value for the field is missing or it does not match the field values list for field 466-EZ.
R24	B	Missing Prescription/ Service Reference Number	The value for the field 4Ø2-D2 is missing.
R25	B	Ineligible Plan	A value for the field 6ØØ-94 is deemed ineligible plan in the contract.
R26	B	Eligible Plan Flag set to 'N' on Plan Flat File 'PD' record	The plan referenced by the Plan ID Qualifier and Plan ID is not covered by the contract as communicated using the Plan Flat File Standard.
R27	B	Ineligible Plan Type of Service on Plan Flat File 'PD' record	The plan referenced by the Plan ID Qualifier and Plan ID is not covered by the contract as communicated using the Plan Flat File Standard.
R28	B	Ineligible Plan Degree Managed on Plan Flat File 'PD' record	The plan referenced by the Plan ID Qualifier and Plan ID is not covered by the contract as communicated using the Plan Flat File Standard.
R29	B	Outside of Plan Eligibility Dates	The plan had been or will be eligible on the contract but not during this rebate period as specified on the HD record.
R3Ø	B	Zero Membership	The Plan ID Qualifier & Plan ID enrollment data is missing or invalid for the rebate period.
R31	B	Plan Contracts Directly With PICO	The plan referenced by the Plan ID Qualifier and Plan ID is not covered by the contract specified on the HD record.
R32	B	Plan Serviced by Another PMO	The plan referenced by the Plan ID Qualifier and Plan ID is not covered by the contract specified on the HD record.
R33	B	Plan's Formulary is Not Effective	The formulary for the Plan ID Qualifier and Plan ID is not active for the specified date of service.
R34	B	PICO Contracts With Pharmacy	The pharmacy referenced by the Pharmacy ID Qualifier and Pharmacy ID is covered by a direct contract.
R35	B	Product Not on Contract	The product referenced by the Product/Service ID Qualifier (436-E1) and Product/Service ID (4Ø7-D7) is not covered by the contract.
R36	B	Product Discontinued	The product referenced by the Product/Service ID Qualifier (436-E1) and Product/Service ID (4Ø7-D7) has been discontinued and is not covered by the contract.
R37	B	Product Repackaged	The product referenced by the Product/Service ID Qualifier (436-E1) and Product/Service ID (4Ø7-D7) has been repackaged and is not covered by the contract.
R38	B	Institutional Product	The product referenced by the Product/Service ID Qualifier (436-E1) and Product/Service ID (4Ø7-D7) is an institutional product not covered by the contract.
R39	B	Product Not on Formulary	The product referenced by the Product/Service ID Qualifier (436-E1) and Product/Service ID (4Ø7-D7) is non-compliant on the formulary. .

CODE	T/B	DESCRIPTION	DEFINITION
R4Ø	B	Ineligible Formulary Code	The supplied formulary code is valid but is not eligible for the specified plan.
R41	B	Product Not Included Within Market Basket	The product referenced by the Product/Service ID Qualifier (436-E1) and Product/Service ID (4Ø7-D7) is not part of the market basket definition.
R42	B	Total Quantity Error	The quantity submitted has an aberrant quantity error.
R43	B	Rebate Days Supply Disputed	The field for Rebate Days Supply is disputed; for example, the value may be considered too high or too low.
R44	B	Date Filled/Date of Service Outside of Contract Period	The prescription is not eligible because its fill date is before the Contract Start Date or after the Contract End Date.
R45	B	Duplicate Prescription within submitting PMOs	The prescription is considered a duplicate because the same submitter has previously submitted the same prescription.
R46	B	Duplicate Prescription across PMOs	The prescription is considered a duplicate because a different submitter has previously submitted the same prescription.
R47	B	Missing/Invalid Patient Liability Amount	Either the value for the field is missing or is not a numeric for field 6Ø1-44.
R48	B	Non-compliant Formulary Status	The formulary status is not compliant with the contract.
R49	B	Product now generic	The product referenced by the Product/Service ID Qualifier (436-E1) and Product/Service ID (4Ø7-D7) is not covered because generic equivalents are now available.
R5Ø	B	Duplicate prescription with Medicaid	The script duplicates a script submitted through a Medicaid program.
R51	B	Missing/Invalid Formulary Code	The formulary code is missing or does not match to the appropriate list.
R52	B	Price Changed	An informational code denoting that the Invoice Price (Fields16Ø-VR, 161-VS, 162-VT, 163-VU, 164-VV) or Paid Base Price (Fields 18Ø-WN, 181-WP, 182-WQ, 183-WR, 184-WS) has changed.
R53	B	Performance Changed	An informational code denoting that the Performance field has changed.
R54	B	Baseline Changed	An informational code denoting that the Baseline field has changed.
R55	B	Level Achieved Changed	An informational code denoting that the Level Achieved field has changed.
R56	B	Invalid Plan ID	A value for the field Plan ID Code (6ØØ-94) cannot be cross-referenced to a list of valid plans.
R57	B	Plan ID ineligible per location	A value for the field Plan ID Code (6ØØ-94) is deemed ineligible per the location of the plan.
R58	B	Plan ID ineligible per type of plan	A value for the field Plan ID Code (6ØØ-94) is deemed ineligible per the type of plan.
R59	B	Plan ID ineligible per other contract terms	A value for the field Plan ID Code (6ØØ-94) is deemed ineligible per other terms defined in the contract.
R6Ø	B	Invalid Pharmacy ID	A value for the field Service Provider ID (2Ø1-B1) cannot be cross-referenced to a list of valid pharmacies.
R61	B	Pharmacy expired	A value for the field Service Provider ID (2Ø1-B1) is deemed expired when compared to a list of valid pharmacies.

CODE	T/B	DESCRIPTION	DEFINITION
B62	B	Pharmacy is in list of excluded pharmacies	A value for the field Service Provider ID (2Ø1-B1) is deemed ineligible per terms defined in the contract.
R63	B	Pharmacy is in list of excluded locations	A value for the field Service Provider ID (2Ø1-B1) is deemed ineligible per the location of the pharmacy.
R64	B	Pharmacy is found in list of excluded types	A value for the field Service Provider ID (2Ø1-B1) is deemed ineligible per type of pharmacy as defined in the contract.
R65	B	Invalid Product ID	A value for the field Product/Service ID (4Ø7-D7) cannot be cross-referenced to a list of valid products.
R66	B	Product ID is in list of excluded products	The product referenced by the Product/Service ID Qualifier (436-E1) and Product/Service ID (4Ø7-D7) is part of a list of excluded products as defined in the contract.
R67	B	Invalid Prescription/Service Reference Number	The value for the field Prescription/Service Reference Number (4Ø2-D2) is in an invalid format.
R68	B	Product in market basket but not rebateable	The product referenced by the Product/Service ID Qualifier (436-E1) and Product/Service ID (4Ø7-D7) is part of the market basket definition but is not a rebate eligible product.
R69	B	Invalid Product package size	The package size submitted is invalid.
R7Ø	B	Duplicate prescription with a Medicare Part D transaction	The script duplicates a script submitted through a Medicare Part D program.
R71	B	Duplicate prescription with a Tricare/Government Agency	The script duplicates a script submitted through a Tricare/Government Agency
R72	B	Duplicate prescription with a SPAP transaction	The script duplicates a script submitted through a SPAP program
R73	B	Duplicate prescription within PMO across submission periods	The script duplicates a script submitted through the same submitting processor but across submission periods.
R74	B	Date Filled/Date of Service Outside of Contract Submission Terms and Conditions	The prescription is not eligible because its fill date is outside of acceptable submission period as defined by the contract terms and conditions.
R75	B	Adjusted Paid Quantity	The quantity paid has been adjusted from what was submitted in the utilization record
R99	B	Other	Any time this code is used, a description of the error must be provided in the Reconciliation Error Description field.
RZ_	B	Reserved range for trading partner codes	RZ_ is reserved for codes to be defined between trading partners. Valid values for the third character are: Ø-9, A-Z

These values used only in Manufacturer Rebates Standard Version Ø3.Ø2. Field values were updated in Manufacturer Rebates Standard Version Ø4.Ø1.

CODE	T/B	DESCRIPTION	DEFINITION
RØ1	T	Missing/Invalid Record Type	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-Ø4.
RØ2	T	Missing/Invalid Line Number	A value has not been provided for the Line Number field (6Ø1-43).
RØ3	T	Duplicate Line Number	Within one transmission or batch, the Line Number field has been duplicated. (Applies only when the optional Line Number field is being filled.)
RØ4	T	Missing/Invalid Data Level	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-31.

CODE	T/B	DESCRIPTION	DEFINITION
RØ5	T	Missing/Invalid Plan ID Qualifier	Either the value for the mandatory field is missing or it does not match the field values list for field 6ØØ-95.
RØ6	B	Missing/Invalid Plan ID Code	A value for the field 6ØØ-94 is missing or cannot be cross-referenced to a list of valid plans (if supplied).
RØ7	T	Missing/Invalid Pharmacy ID Qualifier	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-46.
RØ8	B	Missing/Invalid Pharmacy ID Code	A value for the field 6Ø1-45 is missing or cannot be cross-referenced to a list of valid plans (if supplied).
RØ9	T	Missing/Invalid Product Code Qualifier	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-19.
R1Ø	B	Missing/Invalid Product Code	A value for the field 6Ø1-18 is missing or cannot be cross-referenced to a list of valid products.
R11	B	Missing/Invalid DAW/Product Selection	Either the value for the mandatory field is missing or it does not match the field values for field 4Ø8-Ø8.
R12	T	Missing/Invalid FF Total Metric Decimal Quantity	Either the value for the field is missing or is not a numeric for field 6Ø1-39.
R13	B	Missing/Invalid Unit of Measure	Either the value for the field is missing or it does not match the field values list for field 6ØØ-28.
R14	B	Missing/Invalid Dosage Form ID Code	Either the value for the field is missing or it does not match the field values list for field 6Ø1-34.
R15	B	Missing/Invalid Diagnosis Code	Either the value for the field is missing or it does not match valid ICD-9 codes for field 6ØØ-28.
R16	B	Missing/Invalid Prescription Type	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-49. (Applies only when Data Level is CP or PP.)
R17	B	Missing/Invalid FF Total Number of Prescriptions	Either the value for the field is missing or is not a numeric for field 6Ø1-4Ø.
R18	T	Missing/Invalid Date Filled/Date of Service	Either the value for the field is missing or it does not match the valid date format of CCYYMMDD. (Applies only when Data Level is CP or PP.)
R19	T	Missing/Invalid Therapeutic Class Code Qualifier	Either the value for the field is missing or it does not match the field values list for field 6Ø1-26.
R2Ø	T	Missing/Invalid Plan Reimbursement Qualifier	Either the value for the field is missing or it does not match the field values list for field 6Ø1-45.
R21	B	Missing/Invalid FF New Refill Code	Either the value for the field is missing or it does not match the field values list for field 6Ø1-57.
R22	T	Missing/Invalid Record Purpose Indicator	Either the value for the mandatory field is missing or it does not match the field values list for field 6Ø1-53.
R23	T	Missing/Invalid FF Prescriber ID Qualifier	Either the value for the field is missing or it does not match the field values list for field 6Ø1-38.
R24	B	Missing/Invalid Prescription Number/ Service Reference Number	Either the value for the field 4Ø1-D2 is missing or it does not appear to be valid.
R25	B	Ineligible Plan	The plan referenced by the Plan ID Qualifier and Plan ID is not covered by the contract specified on the HD record.
R26	B	Eligible Plan Flag set to 'N' on Plan FF 'PD' record	The plan referenced by the Plan ID Qualifier and Plan ID is not covered by the contract specified on the HD record as communicated using the Plan Flat File Standard.

CODE	T/B	DESCRIPTION	DEFINITION
R27	B	Ineligible Plan Type of Service on Plan FF 'PD' record	The plan referenced by the Plan ID Qualifier and Plan ID is not covered by the contract specified on the HD record as communicated using the Plan Flat File Standard.
R28	B	Ineligible Plan Degree Managed on Plan FF 'PD' record	The plan referenced by the Plan ID Qualifier and Plan ID is not covered by the contract specified on the HD record as communicated using the Plan Flat File Standard.
R29	B	Outside of Plan Eligibility Dates	The plan had been or will be eligible on the contract but not during this rebate period as specified on the HD record.
R3Ø	B	Zero Membership	The Plan ID Qualifier & Plan ID enrollment data is missing or invalid for the rebate period.
R31	B	Plan Contracts Directly With PICO	The plan referenced by the Plan ID Qualifier and Plan ID is not covered by the contract specified on the HD record.
R32	B	Plan Serviced by Another PMO	The plan referenced by the Plan ID Qualifier and Plan ID is not covered by the contract specified on the HD record.
R33	B	Plan's Formulary is Not Effective	The formulary for the Plan ID Qualifier and Plan ID is not active for the specified date of service.
R34	B	PICO Contracts With Pharmacy	The pharmacy referenced by the Pharmacy ID Qualifier and Pharmacy ID is covered by a direct contract.
R35	B	Product Not on Contract	The product referenced by the Product ID Qualifier and Product ID is not covered by the contract specified on the HD record.
R36	B	Product Discontinued	The product referenced by the Product ID Qualifier and Product ID has been discontinued and is not covered by the contract specified on the HD record.
R37	B	Product Repackaged	The product referenced by the Product ID Qualifier and Product ID has been repackaged and is not covered by the contract specified on the HD record.
R38	B	Institutional Product	The product referenced by the Product ID Qualifier and Product ID is an institutional product not covered by the contract specified on the HD record.
R39	B	Product Not on Formulary	The product referenced by the Product ID Qualifier and Product ID is not on the formulary and therefore is not covered by the contract specified on the HD record.
R4Ø	B	Ineligible Formulary Code	The supplied formulary code is valid but is not eligible for the specified plan.
R41	B	Product Not Included Within Market Basket	The product referenced by the Product ID Qualifier and Product ID is not part of the market basket and is not covered by the contract specified on the HD record.
R42	B	FF Total Metric Decimal Quantity Disputed	The metric quantity is disputed; for example, the value may be considered too high or too low.
R43	B	Rebate Days Supply Disputed	The field for Rebate Days Supply is disputed; for example, the value may be considered too high or too low.
R44	B	Date Filled/Date of Service Outside of Contract Period	The prescription is not eligible because its fill date is before the Contract Start Date or after the Contract End Date.
R45	B	Duplicate Prescription within submitting PMOs	The prescription is considered a duplicate because the same submitter has previously submitted the same prescription.
R46	B	Duplicate Prescription across PMOs	The prescription is considered a duplicate because a different submitter has previously submitted the same prescription.

CODE	T/B	DESCRIPTION	DEFINITION
R47	B	Missing/Invalid Patient Liability Amount	Either the value for the field is missing or is not a numeric for field 6Ø1-44.
R48	B	Non-compliant Formulary Status	The formulary status is not compliant with the contract.
R49	B	Product now generic	The product is not covered because generic equivalents are now available.
R5Ø	B	Duplicate prescription with Medicaid	The script duplicates a script submitted through a Medicaid program.
R51	B	Missing/Invalid Formulary Code	The formulary code is missing or does not match to the appropriate list.
R52	B	Base Price Changed	An informational code denoting that the Base Price field has changed.
R53	B	Performance Changed	An informational code denoting that the Performance field has changed.
R54	B	Baseline Changed	An informational code denoting that the Baseline field has changed.
R55	B	Level Achieved Changed	An informational code denoting that the Level Achieved field has changed.
R99	B	Other	Any time this code is used, a description of the error must be provided in the Reconciliation Error Description field.
RZ_	B	Reserved range for trading partner codes	RZ_ is reserved for codes to be defined between trading partners. Valid values for the third character are: Ø-9, A-Z

F. APPENDIX F – CMS RECONCILIATION REASON CODES FOR STATE DETAIL (RS) RECORDS

Key:

T	=	Technical Reconciliation Reason Code
B	=	Business Reconciliation Reason Code

CODE	T/B	DESCRIPTION	DEFINITION
A	B	Rebate per unit amount has been revised by labeler and reported as required by CMS	CMS Adjustment/Dispute Code A
B	B	Labeler has calculated rebate where none was reported by State	CMS Adjustment/Dispute Code B
C	B	Units involved adjusted through mutual agreement between labeler/State. DO NOT USE this code for prescription times package size discrepancies.	CMS Adjustment/Dispute Code C
D	B	Labeler/State unit discrepancy (e.g., GM vs ML)	CMS Adjustment/Dispute Code D
E	B	Labeler/State decimal discrepancy.	CMS Adjustment/Dispute Code E
F	B	Converted NDC (e.g., correction to package size).	CMS Adjustment/Dispute Code F
G	B	Transferred NDC to another labeler code (documentation required).	CMS Adjustment/Dispute Code G
H	B	Utilization change from the State.	CMS Adjustment/Dispute Code H
I	B	Rebate per unit amount adjusted through correspondence between labeler/state. USE THIS CODE ONLY when the State has reported a rebate per unit that does not reflect an amount based on pricing data reported by the labeler, and adjustment code A is not applicable.	CMS Adjustment/Dispute Code I
N	B	Discontinued/Terminated NDC for which the shelf life expired more than one year ago.	CMS Adjustment/Dispute Code N
O	B	Invalid/miscoded NDC.	CMS Adjustment/Dispute Code O
P	B	State units invoiced exceed expected unit sales. (Attach supporting methodology and data source.)	CMS Adjustment/Dispute Code P
Q	B	Utilization/quantity is inconsistent with the number of prescriptions.	CMS Adjustment/Dispute Code Q
R	B	Utilization/quantity is inconsistent with pharmacy reimbursement levels.	CMS Adjustment/Dispute Code R
S	B	Utilization/quantity is inconsistent with State historical trends.	CMS Adjustment/Dispute Code S
T	B	Utilization/quantity is inconsistent with lowest dispensable package size.	CMS Adjustment/Dispute Code T
U	B	Product not rebate eligible. (Give details.)	CMS Adjustment/Dispute Code U
V	B	No record of sales in State. (Attach data source.)	CMS Adjustment/Dispute Code V
W	B	Closed out. All disputes settled.	CMS Adjustment/Dispute Code W

Note: CMS codes for J, K, L, and M do not exist.

G. APPENDIX G – FORMULARY STATUS CODES

Key:

X	=	Value is applicable for use in field
Blank	=	Value may not be used in field

NAME OF VALUE	VALUES	Non-Listed Prescription Brand Formulary Status (946-GT)	Non-Listed Prescription Generic Formulary Status (947-GU)	Non-Listed Brand Over The Counter Formulary Status (948-GV)	Non-Listed Generic Over The Counter Formulary Status (949-GW)	Non-Listed Supplies Formulary Status (95Ø-GX)	COMMENTS
Unknown	U	X	X	X	X	X	
Not Reimbursable	Ø	X	X	X	X	X	
Non Formulary	1	X	X	X	X	X	
On Formulary (Not Preferred)	2	X	X	X	X	X	
Preferred Level 1	3	X	X	X	X	X	
Preferred Level 2	4	X	X	X	X	X	
Preferred Level 3	5	X	X	X	X	X	
Preferred Levels 4 through 1Ø1	6-99	X	X	X	X	X	

H. APPENDIX H – HEALTH CARE ID CARD VALUES

1. Health Care ID Card Qualifier Codes

Health Care ID Card Qualifier Codes

Definition of Code List	Field Format	Standard/Version Formats	Field Limitations
Health Care ID Card Qualifier Codes enable card issuers to include information such as effective dates of benefit coverage, cardholder address, dependent names and person codes, gender codes, dates of birth, etc. and support full implementation of machine-readable information on Healthcare ID Cards.	x(2)	Health Care ID Card	Maximum Length=2 Minimum Length=2

Values:

CODE	DESCRIPTION
A1	Address line 1
A2	Address line 2
BN	Bank identification number (BIN) or issuer identification number (IIN)
CP	Card purpose code
CY	City
D1 to D9	Dependent date of birth (1-9 represents specific dependent; max of 9 dependents) Format: ccyymmdd
DB	Cardholder date of birth Format: ccyymmdd
DE	Card benefit effective date Format: ccyymmdd
DX	Card expiration date Format: ccyymmdd
DI	Card issued/printed date Format: ccyymmdd
F1 to F9	Dependent first name (1-9 represents specific dependent; max of 9 dependents)
FN	Cardholder first name
G1 to G9	Dependent gender code (1-9 represents specific dependent; max of 9 dependents)
GC	Cardholder gender code Value “1”=Male. Value “2”=Female
GR	Pharmacy benefit group number
L1 to L9	Dependent last name (1-9 represents specific dependent; max of 9 dependents)
LN	Cardholder last name
M1 to M9	Dependent middle initial (1-9 represents specific dependent; max of 9 dependents)
MI	Cardholder middle initial
N1-N9	Dependent name (1-9 represents specific dependent; max of 9 dependents) Composite format of: Surname “/” Given Name “/” Middle Name “/” Suffix, in which “/” is delimiter between components of the name. For example, “JOHN Q PUBLIC JR” is “PUBLIC/JOHN/Q/JR”.
P1 to P9	Dependent person code (1-9 represents specific dependent; max of 9 dependents)
PC	Processor control number

PD	Cardholder person code
PN	Name of primary care physician
PP	Individual NPI of primary care physician
RI	Pharmacy benefit card holder ID - used only when a combination card and the pharmacy cardholder ID differs from the medical cardholder ID
RG	Pharmacy benefit group number – used only when a combination card and the pharmacy group number differs from the medical group number
S1 to S9	Dependent Name suffix; e.g., “JR”, “III”, etc. (1-9 represents specific dependent; max of 9 dependents)
SF	Name suffix; e.g., “JR”, “III”, etc.
ST	State code
WB	Web site URL address
ZP	Zip code (do not include dashes in zip plus numbers)

2. Card Purpose Code

Card Purpose Code

Definition of Code List	Field Format	Standard/Version Formats	Field Limitations
Code to identify the reason the Health Care card is issued.	x(1)	Health Care ID Card	Maximum Length=1 Minimum Length=1

Values:

CODE	DESCRIPTION
A	Admission or re-admission card issued by a health care provider
D	Dental insurance ID card
M	Medical/Surgical insurance ID card
R	Prescription drug insurance ID card
V	Vision insurance ID card
1	Other Health ID card Identifying Medical Records
2	Card Assigning ISO Standard U.S. Healthcare ID such as for Atypical Provider

I. APPENDIX I – VALUES FOR BASIS OF COST DETERMINATION CODES

Used for Basis Of Cost Determination (423-DN) and Compound Ingredient Basis Of Cost Determination (49Ø-UE)

Values:

CODE	DESCRIPTION	Value Limitations
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4. and Post Adjudication Standard Version 1.Ø. Value was deleted and cannot be used in higher versions.
ØØ	Default	
Ø1	AWP (Average Wholesale Price) – A pricing benchmark for prescription drugs.	
Ø2	Local Wholesaler – A legitimate supplier from the surrounding area who resells drugs.	
Ø3	Direct - – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions.	
Ø4	EAC (Estimated Acquisition Cost)-A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs.	
Ø5	Acquisition – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item.	
Ø6	MAC (Maximum Allowable Cost)- Maximum reimbursable ingredient cost amount according to a payer's price list.	
Ø7	Usual & Customary – The pharmacy's price for the medication for a cash paying person on the day of dispensing.	
Ø8	34ØB /Disproportionate Share Pricing/Public Health Service - The 34ØB Drug Pricing Program from the Public Health Service Act, sometimes referred to as "PHS Pricing" or "6Ø2 Pricing" is a federal program that requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics, and hospitals (termed "covered entities") at a reduced price.	
Ø9	Other – Different from those implied or specified.	
1Ø	ASP (Average Sales Price) - The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs.	
11	AMP (Average Manufacturer Price) - The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer.	
12	WAC (Wholesale Acquisition Cost) – A cost as defined in Title XIX, Section 1927 of the Social Security Act.	

J. APPENDIX J – VALUES FOR SPECIALTY CODES

Used for 47Ø7 Provider Specialty, Coded (X12 DE 1222) and 621-RY – Prescriber Specialty

Values: (AMA Self-Designated Practice Specialty/Areas of Practice Codes)

CODE	DESCRIPTION (SPECIALITY)
AS	Abdominal Surgery
ADM	Addiction Medicine

CODE	DESCRIPTION (SPECIALITY)
ADP	Addiction Psychiatry
AMI	Adolescent Medicine (Internal Medicine)

CODE	DESCRIPTION (SPECIALITY)
ADL	Adolescent Medicine (Pediatrics)
OAR	Adult Reconstructive Orthopedics
AM	Aerospace Medicine
A	Allergy
AI	Allergy and Immunology
PTH	Anatomic and Clinical Pathology
ATP	Anatomic Pathology
AN	Anesthesiology
BBK	Blood Banking/Transfusion Medicine
CTS	Cardiothoracic Surgery
CD	Cardiovascular Disease
PCH	Chemical Pathology
CHP	Child and Adolescent Psychiatry
CHN	Child Neurology
PLI	Clinical and Laboratory Immunology (Pediatrics)
DDL	Clinical and Laboratory Dermatological Immunology
ALI	Clinical and Laboratory Immunology (Allergy and Immunology)
ILI	Clinical and Laboratory Immunology (Internal Medicine)
CBG	Clinical Biochemical Genetics
ICE	Clinical Cardiac Electrophysiology
CCG	Clinical Cytogentics
CG	Clinical Genetics
CMG	Clinical Molecular Genetics
CN	Clinical Neurophysiology
CLP	Clinical Pathology
PA	Clinical Pharmacology
CRS	Colon and Rectal Surgery
CCA	Critical Care Medicine (Anesthesiology)
CCM	Critical Care Medicine (Internal Medicine)
NCC	Critical Care Medicine (Neurological Surgery)
OCC	Critical Care Medicine (Obstetrics and Gynecology)
PCP	Cytopathology
DS	Dermatologic Surgery
D	Dermatology
DMP	Dermatopathology (Pathology)
DIA	Diabetes
DR	Diagnostic Radiology
EM	Emergency Medicine
END	Endocrinology, Diabetes, and Metabolism
EP	Epidemiology
FPS	Facial Plastic Surgery

CODE	DESCRIPTION (SPECIALITY)
FP	Family Practice
OFA	Foot and Ankle Orthopedics
FOP	Forensic Pathology
PFP	Forensic Psychiatry
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GS	General Surgery
FPG	Geriatric Medicine (Family Practice)
IMG	Geriatric Medicine (Internal Medicine)
PYG	Geriatric Psychiatry
GO	Gynecological Oncology
GYN	Gynecology
HS	Hand Surgery
HNS	Head and Neck Surgery
HEM	Hematology (Internal Medicine)
HMP	Hematology (Pathology)
HO	Hematology/Oncology
HEP	Hepatology
IG	Immunology
PIP	Immunopathology
ID	Infectious Disease
IM	Internal Medicine
MPD	Internal Medicine/Pediatrics
LM	Legal Medicine
MFM	Maternal and Fetal Medicine
MXR	Maxillofacial Radiology
MG	Medical Genetics
MDM	Medical Management
MM	Medical Microbiology
ON	Medical Oncology
ETX	Medical Toxicology (Emergency Medicine)
PDT	Medical Toxicology (Pediatrics)
PTX	Medical Toxicology (Preventive Medicine)
OMO	Musculoskeletal Oncology
NPM	Neonatal-Perinatal Medicine
NEP	Nephrology
NS	Neurological Surgery
N	Neurology
NRN	Neurology/Diagnostic Radiology/Neuroradiology
NP	Neuropathology
RNR	Neuroradiology
NM	Nuclear Medicine
NR	Nuclear Radiology

CODE	DESCRIPTION (SPECIALITY)
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics and Gynecology
OM	Occupational Medicine
OPH	Ophthalomology
ORS	Orthopedic Surgery
OSS	Orthopedic Surgery of the Spine
OTR	Orthopedic Trauma
OMM	Osteopathic Manipulative Medicine
OS	Other
OTO	Otolaryngology
OT	Otology/Neurotology
APM	Pain Management (Anesthesiology)
PMD	Pain Medicine
PLM	Palliative Medicine
PDA	Pediatric Allergy
PDC	Pediatric Cardiology
CCP	Pediatric Critical Care Medicine
PE	Pediatric Emergency Medicine (Emergency Medicine)
PEM	Pediatric Emergency Medicine (Pediatrics)
PDE	Pediatric Endocrinology
PG	Pediatric Gastroenterology
PHO	Pediatric Hematology/Oncology
PDI	Pediatric Infectious Diseases
PN	Pediatric Nephrology
PO	Pediatric Ophthalmology
OP	Pediatric Orthopedics
PDO	Pediatric Otolaryngology
PP	Pediatric Pathology
PDP	Pediatric Pulmonology
PDR	Pediatric Radiology
PPR	Pediatric Rheumatology
NSP	Pediatric Surgery (Neurological Surgery)
PDS	Pediatric Surgery (Surgery)
UP	Pediatric Urology

CODE	DESCRIPTION (SPECIALITY)
PD	Pediatrics
PM	Physical Medicine and Rehabilitation
PS	Plastic Surgery
PRO	Proctology
P	Psychiatry
PYA	Psychoanalysis
MPH	Public Health and General Preventive Medicine
PUD	Pulmonary Disease
PCC	Pulmonary Disease and Critical Care Medicine
RO	Radiation Oncology
RIP	Radioisotopic Pathology
RP	Radiological Physics
R	Radiology
REN	Reproductive Endocrinology
RHU	Rheumatology
SP	Selective Pathology
SM	Sleep Medicine
SCI	Spinal Cord Injury Medicine (Physical Medicine and Rehabilitation)
ESM	Sports Medicine (Emergency Medicine)
FSM	Sports Medicine (Family Practice)
ISM	Sports Medicine (Internal Medicine)
OSM	Sports Medicine (Orthopedic Surgery)
PSM	Sports Medicine (Pediatrics)
CCS	Surgical Critical Care (Surgery)
SO	Surgical Oncology
TTS	Transplant Surgery
TRS	Trauma Surgery
UM	Undersea Medicine
US	Unspecified
U	Urology
VIR	Vascular and Interventional Radiology
VS	Vascular Surgery

K. APPENDIX K – VALUES FOR COMMUNICATION CODES

Used for 1131 – Code List Qualifier – Communication Number - PVD, PTT, COO Segment (X12 DE 365) and 629-SH – Telephone Number

Values:

CODE	DESCRIPTION

CODE	DESCRIPTION
BN	Beeper
CP	Cellular
EM	Electronic Mail
FX	Fax
HP	Home
NP	Night
TE	Telephone
WP	Work

III. SCRIPT DATA ELEMENT VALUES

A. NCPDP-CREATED DATA ELEMENTS

The following data elements have been created by NCPDP for use in the SCRIPT Standard.

7943 – Administration Timing Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7919 –Body Metric Qualifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the body metric being used (either weight or surface area).	n1	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
1	Kilogram
2	Meter squared

7923 – Calculated Dose Unit of Measure Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7893 - Change of Prescription Status Flag

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used in the CANRX message when the prescriber wishes to notify the pharmacy to no longer continue dispensing any open refills on an active prescription or to cancel a prescription that has not yet been dispensed.	an1	S	Field and values may be used in SCRIPT Standard Version 1Ø.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
C	Cancel - Prescriber wishes to notify the pharmacy to cancel a prescription that has not yet been dispensed.
D	Discontinue - Prescriber wishes to notify the pharmacy to no longer continue dispensing any open refills on an active prescription.

681Ø - Clinical Information Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifies the Clinical Information - primary Diagnosis field.	an..3	S	

Values:

CODE	DESCRIPTION
1	Prescriber/Prescriber Supplied – The diagnosis was given or supplied by the prescriber.
2	Pharmacy Inferred - The pharmacy inferred the diagnosis using his/her professional judgment.

1131 – Code List Qualifier – Diagnosis Code Qualifier (Primary) - DRU Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifies the code list used for the Diagnosis. Where available, X12 DE 235 values are listed for code sets.	an..3	S	

Values:

CODE	DESCRIPTION
E	Micromedex/Medical Economics – a code list developed by this company
F	First DataBank – a code list developed by this company
M	Medi-Span Product Line - a code list developed by this company
DX	International Classification of Diseases-9- Clinical Modifications-Diagnosis (ICD-9-CM-Diagnosis) Code indicating the diagnosis is defined according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. Most codes are numeric and consist of 3, 4, or 5 numbers and a description. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services.
ABF	International Classification of Diseases-1Ø- Clinical Modifications (ICD-1Ø-CM) Code indicating that the following information is a diagnosis as defined by ICD-1Ø-CM. As of January 1, 1999, the ICD-1Ø is used to code and classify mortality data from death certificates. The International Classification of Diseases, 1Øth Revision, Clinical Modification (ICD-9-CM)is a statistical classification system that arranges diseases and injuries into groups according to established criteria. The codes are 3 to 7 digits with the first digit alpha, the second and third numeric and the remainder A/N. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services.

1131 – Code List Qualifier – Response Code - RES Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Codes used in response messages by	an..3	S	

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
the ultimate receiver.			

Values:

CODE	DESCRIPTION
AA	Patient unknown to the Prescriber
AB	Patient never under Prescriber care
AC	Patient no longer under Prescriber care
AD	Patient has requested refill too soon
AE	Medication never prescribed for the patient
AF	Patient should contact Prescriber first
AG	Refill not appropriate
AH	Patient has picked up prescription
AJ	Patient has picked up partial fill of prescription
AK	Patient has not picked up prescription, drug returned to stock
AL	Change not appropriate
AM	Patient needs appointment
AN	Prescriber not associated with this practice or location.
AO	No attempt will be made to obtain Prior Authorization
AP	Request already responded to by other means (e.g. phone or fax)
AQ	More Medication History Available

1131 – Code List Qualifier – Reject Code - STS Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Reject Codes used by responder who takes responsibility for transaction	an..3	S	

Values:

CODE	DESCRIPTION
ØØ1	Sender ID not on file.
ØØ2	Receiver ID not on file.
ØØ3	Invalid password for sender.
ØØ4	Invalid password for receiver
ØØ5	No password on file for sender.
ØØ6	No password on file for receiver.
ØØ7	Internal processing error has occurred.
ØØ8	Request timed out before response could be received.
ØØ9	Required segment UIB is missing.
Ø1Ø	Required segment UIH is missing.
Ø11	Required segment UIT is missing.
Ø12	Required segment UIZ is missing.
Ø13	Unknown segment has been encountered.
Ø14	Too many UIB segments.
Ø15	Too many UIH segments.

CODE	DESCRIPTION
Ø16	Too many UIT segments.
Ø17	Too many UIZ segments.
Ø18	Password is blank.
Ø19	Too many segments.
Ø2Ø	Unknown data element encountered.
Ø21	Unsupported version in message.
Ø22	Unsupported release in message.
Ø23	Error found in an unused field.
Ø24	Message ending problem.
Ø25	UIB trace number is invalid.
Ø26	UIB initiator reference is invalid.
Ø27	UIB control agency is invalid.
Ø28	UIB sender identification is invalid.
Ø29	UIB date is invalid.
Ø3Ø	UIB time is invalid.
Ø31	UIB time offset is invalid.

CODE	DESCRIPTION
Ø32	UIB duplicate flag is invalid.
Ø33	UIB test flag is invalid.
Ø34	UIH message type is invalid.
Ø35	UIH function is invalid.
Ø36	UIH association code is invalid.
Ø37	UIH prescription number is invalid.
Ø38	UIH initiator reference is invalid.
Ø39	UIH initiator reference identifier is invalid.
Ø4Ø	UIH control agency is invalid.
Ø41	UIH responder control reference is invalid.
Ø42	REQ message function is invalid.
Ø43	REQ reason code is invalid.
Ø44	REQ reference is invalid.
Ø45	REQ old password is invalid.
Ø46	REQ new password is invalid.
Ø47	RES response type is invalid.
Ø48	RES response code is invalid.
Ø49	RES reference is invalid.
Ø5Ø	RES free text is invalid.
Ø51	STS status code is invalid.
Ø52	STS reject code is invalid.
Ø53	STS free text is invalid.
Ø54	PVD provider type is invalid.
Ø55	PVD reference is invalid.
Ø56	PVD reference qualifier is invalid.
Ø57	PVD agency qualifier is invalid.
Ø58	PVD specialty, coded is invalid.
Ø59	PVD prescriber last name is invalid.
Ø6Ø	PVD prescriber first name is invalid.
Ø61	PVD prescriber middle name is invalid.
Ø62	PVD prescriber name suffix is invalid.
Ø63	PVD prescriber name prefix is invalid.
Ø64	PVD prescriber postal code is invalid.
Ø65	PVD clinic name is invalid.
Ø66	PVD clinic street is invalid.
Ø67	PVD clinic city is invalid.
Ø68	PVD clinic country is invalid.
Ø69	PVD clinic postal code is invalid.
Ø7Ø	PVD clinic place qualifier is invalid.
Ø71	PVD clinic place name is invalid.
Ø72	PVD communication reference is invalid.
Ø73	PVD communication qualifier is invalid.
Ø74	PVD agent last name is invalid.
Ø75	PVD agent first name is invalid.
Ø76	PVD agent middle name is invalid.

CODE	DESCRIPTION
Ø77	PVD agent name suffix is invalid.
Ø78	PVD agent name prefix is invalid.
Ø79	PTT patient relationship is invalid.
Ø8Ø	PTT patient birth date is invalid.
Ø81	PTT patient last name is invalid.
Ø82	PTT patient first name is invalid.
Ø83	PTT patient middle name is invalid.
Ø84	PTT patient name suffix is invalid.
Ø85	PTT patient name prefix is invalid.
Ø86	PTT patient gender is invalid.
Ø87	PTT patient reference is invalid.
Ø88	PTT patient reference qualifier is invalid.
Ø89	PTT patient street is invalid.
Ø9Ø	PTT patient city is invalid.
Ø91	PTT patient country is invalid.
Ø92	PTT patient postal code is invalid.
Ø93	PTT patient place qualifier is invalid.
Ø94	PTT patient place name is invalid.
Ø95	PTT communication reference is invalid.
Ø96	PTT communication reference qualifier is invalid.
Ø97	COO payer reference is invalid.
Ø98	COO payer reference qualifier is invalid.
Ø99	COO payer name is invalid.
1ØØ	COO service type is invalid.
1Ø1	COO cardholder reference is invalid.
1Ø2	COO cardholder reference qualifier is invalid.
1Ø3	COO cardholder name is invalid.
1Ø4	COO group reference is invalid.
1Ø5	COO group name is invalid.
1Ø6	COO group street is invalid.
1Ø7	COO group city is invalid.
1Ø8	COO group country is invalid.
1Ø9	COO group postal code is invalid.
11Ø	COO group place qualifier is invalid.
111	COO group place name is invalid.
112	COO datetime qualifier is invalid.
113	COO datetime is invalid.
114	COO datetime format qualifier is invalid.
115	COO insurance type is invalid.
116	COO holder street is invalid.
117	COO holder city is invalid.
118	COO holder country is invalid.
119	COO holder postal code is invalid.
12Ø	COO holder place qualifier is invalid.

CODE	DESCRIPTION
121	COO holder place name is invalid.
122	COO holder reference is invalid.
123	COO holder reference qualifier is invalid.
124	COO response code is invalid.
125	DRU drug disposition code is invalid.
126	DRU drug name is invalid.
127	DRU drug item number is invalid.
128	DRU drug agency is invalid.
129	DRU drug agency qualifier is invalid.
13Ø	DRU drug strength is invalid.
131	DRU drug strength qualifier is invalid.
132	DRU drug reference is invalid.
133	DRU drug reference qualifier is invalid.
134	DRU dosage quantity qualifier is invalid.
135	DRU dosage quantity is invalid.
136	DRU dosage info qualifier is invalid.
137	DRU dosage info is invalid.
138	DRU dosage free text is invalid.
139	DRU datetime qualifier is invalid.
14Ø	DRU datetime is invalid.
141	DRU datetime format qualifier is invalid.
142	DRU substitution code is invalid.
143	DRU refill quantity qualifier is invalid.
144	DRU refill quantity is invalid.
145	DRU clinical info qualifier is invalid.
146	DRU clinical info level1 reference is invalid
147	DRU clinical info level1 qualifier is invalid.
148	DRU clinical info level2 reference is invalid.
149	DRU clinical info level2 qualifier is invalid.
15Ø	DRU prior authorization reference is invalid.
151	DRU prior authorization qualifier is invalid.
152	DRU free text is invalid.
153	OBS measurement dimension is invalid.
154	OBS measurement value is invalid.
155	OBS measurement qualifier is invalid.
156	OBS datetime is invalid.
157	OBS datetime qualifier is invalid.
158	OBS free text is invalid.
159	UIT reference number is invalid.
16Ø	UIT segment count is invalid.
161	UIZ dial reference is invalid.
162	UIZ dial identifier is invalid.
163	UIZ control agency is invalid.
164	UIZ responder control ref is invalid.
165	UIZ message count is invalid.

CODE	DESCRIPTION
166	Too many elements in COO segment.
167	Too many elements in DRU segment.
168	Too many elements in OBS segment.
169	Too many elements in PTT segment.
17Ø	Too many elements in PVD segment.
171	Too many elements in REQ segment.
172	Too many elements in RES segment.
173	Too many elements in STS segment.
174	Too many elements in UIB segment.
175	Too many elements in UIH segment.
176	Too many elements in UIT segment.
177	Too many elements in UIZ segment.
178	Too many COO segments.
179	Too many DRU segments.
18Ø	Too many OBS segments.
181	Too many PTT segments.
182	Too many PVD segments.
183	Too many REQ segments.
184	Too many RES segments.
185	Too many STS segments.
186	Too many UNA segments.
187	Too many COO element repetitions.
188	Too many DRU element repetitions.
189	Too many OBS element repetitions.
19Ø	Too many PTT element repetitions.
191	Too many PVD element repetitions.
192	Too many REQ element repetitions.
193	Too many RES element repetitions.
194	Too many STS element repetitions.
195	Too many UIB element repetitions.
196	Too many UIH element repetitions.
197	Too many UIT element repetitions.
198	Too many UIZ element repetitions.
199	Segment count mismatch in UIT.
2ØØ	Message missing required REQ segment.
2Ø1	Message missing required RES segment.
2Ø2	Message missing required STS segment.
2Ø3	Message missing required PVD segment.
2Ø4	Message missing required PTT segment.
2Ø5	Message missing required COO segment.
2Ø6	Message missing required DRU segment.
2Ø7	Message missing required OBS segment.
2Ø8	Sender no longer active.
2Ø9	Receiver no longer active.

CODE	DESCRIPTION
21Ø	Unable to process transaction. Please resubmit.
211	DUE Reason For Service Code is invalid.
212	DUE Professional Service Code is invalid.
213	DUE Result Of Service Code is invalid.
214	DUE Co-Agent ID is invalid.
215	DUE Co-Agent ID Qualifier is invalid.
216	Drug Coverage Status Code is invalid.
217	COO Date/Time/Period Expiration date - of needed history is less than Effective Date (Begin) of needed history
218	COO Patient Identifier is invalid
219	COO Cannot process Medication History due to value of Condition/Response, coded (Patient Consent Indicator)
22Ø	Message is a duplicate
221	Needed No Later Than Reason Date/Time Period Qualifier is invalid
222	Needed No Later Than Reason Date/Time/Period is invalid
223	Needed No Later Than Reason Date/Time/Period Format Qualifier is invalid
224	DRU Time Zone Identifier is invalid
225	DRU Time Zone Difference Quantity is invalid
226	Needed No Later Than Reason is invalid
227	Message missing required SRC Segment
228	SRC Source Qualifier is invalid
229	SRC Source Description is invalid
23Ø	SRC Source Reference Number is invalid
231	SRC Source Reference Qualifier is invalid
232	SRC Reference Number is invalid
233	SRC Fill Number is invalid
234	Too many SRC Segments
235	Too many SRC element repetitions
236	Too many elements in SRC Segment
237	SIG Sig Sequence Position Number is invalid
238	SIG Multiple Sig Modifier is invalid
239	SIG SNOMED Version is invalid
24Ø	SIG FMT Version is invalid
241	SIG Sig Free Text String Indicator is invalid
242	SIG Sig Free Text is invalid
243	SIG Dose Composite Indicator is invalid
244	SIG Dose Delivery Method Text is invalid
245	SIG Dose Delivery Method Code Qualifier is invalid
246	SIG Dose Delivery Method Code is invalid

CODE	DESCRIPTION
247	SIG Dose Delivery Method Modifier Text is invalid
248	SIG Dose Delivery Method Modifier Code Qualifier is invalid
249	SIG Dose Delivery Method Modifier Code is invalid
25Ø	SIG Dose Quantity is invalid
251	SIG Dose Form Text is invalid
252	SIG Dose Form Code Qualifier is invalid
253	SIG Dose Form Code is invalid
254	SIG Dose Range Modifier is invalid
255	SIG Dosing Basis Numeric Value is invalid
256	SIG Dosing Basis Unit of Measure Text is invalid
257	SIG Dosing Basis Unit of Measure Code Qualifier is invalid
258	SIG Dosing Basis Unit of Measure Code is invalid
259	SIG Body Metric Qualifier is invalid
26Ø	SIG Body Metric Value is invalid
261	SIG Calculated Dose Numeric is invalid
262	SIG Calculated Dose Unit of Measure Text is invalid
263	SIG Calculated Dose Unit of Measure Code Qualifier is invalid
264	SIG Calculated Dose Unit of Measure Code is invalid
265	SIG Dosing Basis Range Modifier is invalid
266	SIG Vehicle Name is invalid
267	SIG Vehicle Name Code Qualifier is invalid
268	SIG Vehicle Name Code is invalid
269	SIG Vehicle Quantity is invalid
27Ø	SIG Vehicle Unit Of Measure Text is invalid
271	SIG Vehicle Unit Of Measure Code Qualifier is invalid
272	SIG Vehicle Unit Of Measure Code is invalid
273	SIG Multiple Vehicle Modifier is invalid
274	SIG Route of Administration Text is invalid
275	SIG Route of Administration Code Qualifier is invalid
276	SIG Route of Administration Code is invalid
277	SIG Multiple Route of Administration Modifier is invalid
278	SIG Site of Administration Text is invalid
279	SIG Site of Administration Code Qualifier is invalid
28Ø	SIG Site of Administration Code is invalid
281	SIG Multiple Administration Timing Modifier is invalid

CODE	DESCRIPTION
282	SIG Administration Timing Text is invalid
283	SIG Administration Timing Code Qualifier is invalid
284	SIG Administration Timing Code is invalid
285	SIG Multiple Administration Timing Modifier is invalid
286	SIG Rate of Administration is invalid
287	SIG Rate Unit of Measure Text is invalid
288	SIG Rate Unit of Measure Code Qualifier is invalid
289	SIG Rate Unit of Measure Code is invalid
29Ø	SIG Time Period Basis Text is invalid
291	SIG Time Period Basis Code Qualifier is invalid
292	SIG Time Period Basis Code is invalid
293	SIG Frequency Numeric Value is invalid
294	SIG Frequency Units Text is invalid
295	SIG Frequency Units Code Qualifier is invalid
296	SIG Frequency Units Code is invalid
297	SIG Variable Frequency Modifier is invalid
298	SIG Interval Numeric Value is invalid
299	SIG Interval Units Text is invalid
3ØØ	SIG Interval Units Code Qualifier is invalid
3Ø1	SIG Interval Units Code is invalid
3Ø2	SIG Variable Interval Modifier is invalid
3Ø3	SIG Duration Numeric Value is invalid
3Ø4	SIG Duration Text is invalid
3Ø5	SIG Duration Text Code Qualifier is invalid
3Ø6	SIG Duration Text Code is invalid
3Ø7	SIG Maximum Dose Restriction Numeric Value is invalid
3Ø8	SIG Maximum Dose Restriction Units Text is invalid
3Ø9	SIG Maximum Dose Restriction Code Qualifier is invalid
31Ø	SIG Maximum Dose Restriction Units Code is invalid
311	SIG Maximum Dose Restriction Variable Numeric Value is invalid
312	SIG Maximum Dose Restriction Variable Units Text is invalid
313	SIG Maximum Dose Restriction Variable Units Code Qualifier is invalid
314	SIG Maximum Dose Restriction Variable Units Code is invalid
315	SIG Maximum Dose Restriction Variable Duration Modifier is invalid
316	SIG Indication Precursor Text is invalid

CODE	DESCRIPTION
317	SIG Indication Precursor Code Qualifier is invalid
318	SIG Indication Precursor Code is invalid
319	SIG Indication Text is invalid
32Ø	SIG Indication Text Code Qualifier is invalid
321	SIG Indication Text Code is invalid
322	SIG Indication Value Text is invalid
323	SIG Indication Value Unit is invalid
324	SIG Indication Value Unit of Measure Text is invalid
325	SIG Indication Value Unit of Measure Code Qualifier is invalid
326	SIG Indication Value Unit of Measure Code is invalid
327	SIG Indication Variable Modifier is invalid
328	SIG Stop Indicator is invalid
329	Message missing required SIG Segment
33Ø	Too many SIG Segments
331	Too many SIG element repetitions
332	Too many elements in SIG Segment
333	Service Type, coded Current flag is not supported
334	Source code list for item form code is invalid
335	Source code list for item strength code is invalid
336	Source code list for potency unit code is invalid
337	Source code list for measurement unit code is invalid
338	DEA Schedule is invalid
339	DRU item form code is invalid.
34Ø	DRU item strength code is invalid.
341	DRU potency unit code is invalid.
342	OBS measurement unit code is invalid.
343	PVD Provider Specialty code is invalid.

13Ø-4711 Condition/Response, coded - Patient Consent Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Patient Consent Indicator	an..3	S	Field and values may be used in SCRIPT Standard Version 8.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
Y	Patient gave consent for prescriber to receive the medication history from any prescriber.
N	Patient consent not given.
P	Patient gave consent for prescriber to only receive the medication history this prescriber prescribed.
X	Parental/Guardian consent on behalf of a minor for prescriber to receive the medication history from any prescriber.
Z	Parental/Guardian consent on behalf of a minor for prescriber to only receive the medication history this prescriber prescribed.

3229 - Country Sub-entity Identification

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
United States and Canadian Province Postal Service Abbreviations.	an..9	S	Field and values may be used in SCRIPT Standard Version 1Ø.5 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
	See Section II, APPENDIX C - UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS

7996 - DEA Schedule

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Value defining the DEA schedule of the medication.	an..15	S	Field and values may be used in SCRIPT Standard Version 1Ø.5 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
	NCI Administrative Concept - Research Resource - Information Resource - Terminology Subset - Structured Product Labeling Terminology - Structured Product Labeling DEA Schedule Terminology - *Schedule of Controlled Substances* (http://www.cancer.gov/cancertopics/terminologyresources/page4- NCI Thesaurus)

7892 - Do Not Fill/Profile Flag

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used for medications ordered by a prescriber but not requiring dispensing at this time, but required for administration and available for drug-to-drug interactions.	an1	S	Field and values may be used in SCRIPT Standard Version 1Ø.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
Y	Yes

7925 – Dose Basis Range Modifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used to signify that the Sig contains more than one dose which represent a dose range (TO) or contains a dose option (OR).	an..5Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix BB (Section III-A)	

79Ø3 – Dose Composite Indicator - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the action to be taken on the Dose Composite fields.	n1	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
1	Specified - remaining fields populated
2	As needed - skip rest of Dose Segment.
3	As directed - skip rest of Dose Segment.
4	Unspecified - see free text.

79Ø5 – Dose Delivery Method Code Qualifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

79Ø8 – Dose Delivery Method Modifier Code Qualifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7912 – Dose Form Code Qualifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7914 – Dose Range Modifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used to signify that the Sig contains more than one dose in a range or option.	an..5Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix BB (Section III-A)	

7917 – Dosing Basis Unit of Measure Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7885 - Drug Coverage Status Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the coverage status of the prescribed drug.	an2	S	

Values:

CODE	DESCRIPTION
PR	Preferred - Preferred means available on a pharmaceutical formulary in a manner such that the product is given preference in dispensing decisions over competing products in a

CODE	DESCRIPTION
	therapeutic class or therapeutic use.
AP	Approved - The product is included in the plan formulary.
PA	Prior Authorization Required - A prior authorization is required before the prescription can be dispensed.
NF	Non Formulary - The product is not included in the plan formulary.
NR	Not Reimbursed - The product is not reimbursable in the plan formulary.
DC	Differential Co-Pay - The product may be subject to potentially higher copay.
UN	Unknown - The coverage status code is not discernible.
ST	Step Therapy Required – The plan formulary requires that medication in a specific drug class be tried prior to the requested medication.

7882 - DUE Co-Agent ID Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code qualifying the value in DUE Co-Agent ID.	an2	SCRIPT	May be used in SCRIPT Standard Version 5.Ø or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Section II – ***475-J9 – DUR Co-Agent ID Qualifier***	

7965 – Duration Text Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7955 – Frequency Units Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7977 – Indication Precursor Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
			lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

798Ø – Indication Text Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7985 – Indication Value Unit of Measure Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7987 –Indication Variable Modifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used to express when there is more than one INDICATION as to whether all the indications must apply (AND) or if any of the indications can apply (OR).	an..5Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix DD (Section III-A)	

97Ø1 - Individual Relationship, coded

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Defines the relationship of patient to cardholder.	an..3	S	

Values:

CODE	DESCRIPTION

CODE	DESCRIPTION
1	Cardholder – Patient is the cardholder
2	Spouse – Patient is the husband/wife/partner of the cardholder
3	Child/Dependent – Patient is a child/dependent of the cardholder
4	Other – Relationship to cardholder is not known

796Ø – Interval Units Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7992 - Item Form Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Drug form, in a code. Dosage form code. Pharmaceutical Dosage Form. Qualified by Source Code List (7991).	an..15	S	Field and values may be used in SCRIPT Standard Version 1Ø.5 or greater but not in lower versions. For SCRIPT Standard Versions 5.Ø through 1Ø.4 refer to 1131 – Code List Qualifier – Drug Form - DRU Segment (X12 DE 133Ø) in Section III-B.

Values:

CODE	DESCRIPTION
	NCI values of Diagnostic, Therapeutic, and Research Equipment - **Pharmaceutical Dosage Form** (http://www.cancer.gov/cancertopics/terminologyresources/page4- NCI Thesaurus)

7993 - Item Strength Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Drug strength qualifier. Units of Presentation. Qualified by Source Code List (7991).	an..15	S	Field and values may be used in SCRIPT Standard Version 1Ø.5 or greater but not in lower versions. For SCRIPT Standard Versions 5.Ø through 1Ø.4 refer to 1131 – Code List Qualifier – used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier in Section III-B.

Values:

CODE	DESCRIPTION
	NCI values of **Units of Presentation** (http://www.cancer.gov/cancertopics/terminologyresources/page4- NCI Thesaurus)

7969 – Maximum Dose Restriction Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7975 – Maximum Dose Restriction Variable Duration Modifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used to express when there is more than one DURATION as to whether the durations are all required to be used (AND) or if any of the durations can be used (OR).	an..5Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix CC (Section III-A)	

7973 – Maximum Dose Restriction Variable Units Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7887- Measurement Data Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Identifies code set of clinical physical findings.	an..3	S	(May be used in SCRIPT Standard Version 1Ø.Ø or greater but not in lower versions.)

Values:

CODE	DESCRIPTION
1	X-12 Data Element Measurement Dimension, coded (DE 738)
2	SNOMED Systematized Nomenclature of Medicine--Clinical Terms (SNOMED) is available at http://www.nlm.nih.gov/research/umls/ or www.snomed.org
3	LOINC Logical Observation Identifiers Names and Codes (LOINC®) is available at http://www.regenstrief.org/loinc/
4	Other

7995 - Measurement Unit Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Basis for measurement code. Units of Presentation. Qualified by Source Code List (7991).	an..15	S	Field and values may be used in SCRIPT Standard Version 1Ø.5 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
	NCI values of **Units of Presentation** (http://www.cancer.gov/cancertopics/terminologyresources/page4- NCI Thesaurus)

4343 – Message Function, coded

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used in Prescription Change Request transactions, to request a change to the original new prescription.	an..3	S	

Values:

CODE	DESCRIPTION
G	Generic Substitution – A modification of the product prescribed to a generic equivalent.
T	Therapeutic Interchange/Substitution – A modification of the product prescribed to a preferred product choice
P	Prior Authorization Required – A request to obtain prior authorization before dispensing.
A	Admit -The patient is a new admission; demographic information included to populate basic patient information (long term care settings).
C	Change - The status of a patient has changed (long term care settings). **Update Patient Information**
C1	**Label** change (Any changes to the Drug, form, strength, dosage, or route) – Change to an active order to the drug, form, strength, dosage, or route (long term care settings).
C2	Frequency Change (Any change to the frequency or hours of administration for the drug) - Change to the frequency or hours of administration for the medication (long term care settings).
C3	Other Change (All other changes) – A change to the medication not covered by other values listed (long term care settings).
D1	Discharge – Expired - The patient has been discharged due to death (long term care settings).
D2	Discharge – Return Not Anticipated - The patient has been discharged and not expected to return to site (long term care settings).
D3	Discharge – Return Anticipated - The patient has been discharged and is expected to return to site (long term care settings).
D4	Discharge Other – The patient has been discharged for an unknown reason (long term care settings).
CT	Transfer a Patient - A patient moves from one location to another within the care setting. For example, a patient is transferred to another ward, room or bed.
PA	Pre-Admit - A prospective patient has been recorded prior to arrival at the care setting for an inpatient stay.
LT	Therapeutic Leave of Absence - An inpatient leaves the care setting for an overnight absence to visit friends or relatives or to participate in a therapeutic or rehabilitative plan of care.
LG	Hospital Leave of Absence - An inpatient leaves the care setting for an overnight absence to a hospital.
LR	Return from Leave of Absence - An inpatient returns to the care setting from a hospital leave of absence or therapeutic leave of absence.
RO	Register outpatient - A patient has arrived or checked in as an outpatient, recurring outpatient, or emergency room patient.

CODE	DESCRIPTION
OI	Change outpatient to inpatient - An outpatient or ER patient is being admitted as an inpatient.
IO	Change inpatient to outpatient - An inpatient becomes an outpatient and is still receiving care/services.
AC	Admit Cancel - A previously communicated admission or outpatient registration is canceled, either because of an erroneous entry or because of a revised decision to not admit the patient.
TC	Transfer Cancel - A previously communicated transfer is cancelled, either because of an erroneous entry or because of a revised decision to not transfer the patient.
DC	Discharge Cancel - A previously communicated discharge is cancelled, either because of erroneous entry or because of a revised decision to not discharge, or end the visit of, the patient.
PC	PreAdmit Cancel - A previously communicated pre-admission is canceled, either because of an erroneous entry or because of a revised decision to not pre-admit the patient.
LC	Leave of Absence Cancel - A previously communicated hospital leave of absence or therapeutic leave of absence is canceled, either because of an erroneous entry or because of a revised decision.
RC	Return from Leave Cancel - A previously communicated patient return from a leave of absence (hospital or therapeutic) is canceled, either because of an erroneous entry or because of a revised decision.

7945 –Multiple Administration Timing Modifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used to express when there is more than one ADMINISTRATION TIME as to whether the times are all required to be used (AND) or if any of the times can be used (OR).	an..5Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix CC (Section III-A)	

7937 –Multiple Route of Administration Modifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used to express when there is more than one route as to whether the routes are all required to be used (AND) or if any of the routes can be used (OR).	an..5Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix CC (Section III-A)	

7899 – Multiple Sig Modifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used to express when there is more than one Sig as to whether all the Sigs must apply (AND) or if any of the Sigs can apply (OR) or if the Sigs are sequential (THEN), in the sequence	an..5Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
defined by Sig SEQUENCE POSITION.			

Values: Provided definitions

CODE	DESCRIPTION
AND	All must apply/must be used
OR	Any can apply/can be used
THEN	See Siq Sequence Position for order of sequence of sigs

7941 – Multiple Site of Administration Timing Modifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used to express when there is more than one site as to whether the sites are all required (AND) for use or excluded from use (NOT) or if any of the sites can be used (OR).	an..5Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
AND	All must apply/must be used
OR	Any can apply/can be used
NOT	Excluded from use

7933 – Multiple Vehicle Modifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Denotes if for an instance of more than one vehicle if all vehicles are used together (AND), or if each of the listed vehicles is an option (OR).	an..5Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix CC (Section III-A)	

7994 - Potency Unit Code

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Unit of measure. Potency Unit. Qualified by Source Code List (7991).	an..15	S	Field and values may be used in SCRIPT Standard Version 1Ø.5 or greater but not in lower versions. For SCRIPT Standard Versions 5.Ø through 1Ø.4 refer to 1131 – Code List Qualifier – used for 6Ø63 - Quantity Qualifier (X12 DE 355) in Section III-B.

Values:

CODE	DESCRIPTION

CODE	DESCRIPTION
	NCI values of Property or Attribute - Unit of Measure - Unit of Category - **Potency Unit** (http://www.cancer.gov/cancertopics/terminologyresources/page4- NCI Thesaurus)

7891- Prior Authorization Status

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The status of the prescription's prior authorization as known by the sender.	an1	S	(May be used in SCRIPT Standard Version 1Ø.Ø or greater but not in lower versions.)

Values:

CODE	DESCRIPTION
A	Approved – The medication was approved by the payer
D	Denied - The medication was not approved by the payer.
F	Deferred - The medication request being reviewed by the payer.
N	Not Required - A prior authorization is not required for this medication.
R	Requested - The action of obtaining a prior authorization approval is being sought.

799Ø - Provider Specialty code (replacing 47Ø7 - Provider Specialty, coded (X12 DE 1222)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The Health Care Provider Taxonomy code set includes specialty categories for individuals, Groups of individuals, and non-individuals. The National Uniform Claims Committee maintains this code set.	an..1Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.5 or greater but not in lower versions. For SCRIPT Standard Versions 5.Ø through 1Ø.4 refer to 47Ø7 – Provider Specialty, coded (X12 DE 1222) in Section III-B.

Values:

CODE	DESCRIPTION
	The National Uniform Claims Committee maintains this code set. The complete code set is available from the Washington Publishing Company at www.wpc-edi.com/taxonomy/more_information

7948 – Rate Unit of Measure Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

1153 – Reference Qualifier– Generic Database, Prior Authorization - DRU Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code value to define the reference number GPI, GCN Seq #, GFC, DDID, SmartKey, GM, Multum MMDC, Multum Drug ID, etc	an..3	S	See Section II, Appendix B2 – Drug Reference Values.

7935 – Route of Administration Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

79Ø2 –Sig Free Text String Indicator - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the system capability of representing the instructions.	n1	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
1	Capture what the doctor ordered.
2	Reconstructed from structured Sig.
3	Pure free text.

7939 – Site of Administration Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7991 - Source Code List

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Code identifying the source organization.	an..3	S	Field and values may be used in SCRIPT Standard Version 1Ø.5 or greater but not in lower versions. For SCRIPT Standard

			Versions 5.Ø through 1Ø.4 refer to 1131 – Code List Qualifier – Drug Form - DRU Segment (X12 DE 133Ø), 1131 – Code List Qualifier – used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier,, and 1131 – Code List Qualifier – used for 6Ø63 - Quantity Qualifier (X12 DE 355) in Section III-B.

Values:

CODES	DESCRIPTION
AA	NCI values of Diagnostic, Therapeutic, and Research Equipment - **Pharmaceutical Dosage Form** (http://www.cancer.gov/cancertopics/terminologyresources/page4- NCI Thesaurus)
AB	NCI values of **Units of Presentation** (http://www.cancer.gov/cancertopics/terminologyresources/page4- NCI Thesaurus)
AC	NCI values of Property or Attribute - Unit of Measure - Unit of Category - **Potency Unit** (http://www.cancer.gov/cancertopics/terminologyresources/page4- NCI Thesaurus)

9Ø15- Status Type, coded

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Codes used to relay successful or rejected communications.	an..3	S	

Values:

CODE	DESCRIPTION
ØØØ	Transaction successful
ØØ1	Transaction successful, message(s) waiting to be retrieved
ØØ2	No more messages
ØØ3	Transaction successful, no messages to be retrieved
ØØ5	Transaction successful, password soon to expire
Ø1Ø	Successful – accepted by ultimate receiver
6ØØ	Communication problem - try again later
6Ø1	Receiver unable to process
6Ø2	Receiver System Error
9ØØ	Transaction rejected

7988 –Stop Indicator - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Defines if a stop is present.	an1	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION

CODE	DESCRIPTION
Blank	Not Specified
Y	Yes
N	No

7951 – Time Period Basis Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7957 –Variable Frequency Modifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used to express when there is more than one FREQUENCY as to whether the frequencies are all required to be used (AND) or if any of the frequencies can be used (OR).	an..5Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix DD (Section III-A)	

7962 –Variable Interval Modifier - SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used to express when there is more than one INTERVAL as to whether the intervals are all required to be used (AND) or if any of the intervals can be used (OR/TO).	an..5Ø	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix DD (Section III-A)	

7927 – Vehicle Name Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

7931 – Vehicle Unit of Measure Code Qualifier – SIG Segment

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifier to identify the code system being used	an..2	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
See Appendix AA (Section III-A)	

1. Appendix AA – SIG Segment Qualifier Values

Values:

CODE	DESCRIPTION
1	SNOMED Systematized Nomenclature of Medicine--Clinical Terms (SNOMED) is available at http://www.nlm.nih.gov/research/umls/ or www.snomed.org
2	FMT Federal Medication Therapy—Codes maintained by the National Cancer Institute, available at http://www.cancer.gov/cancertopics/terminologyresources/FDA

2. Appendix BB – SIG Segment Dose Range Values

Values:

CODE	DESCRIPTION
TO	A range
OR	An option

3. Appendix CC – SIG Segment Modifier Values

Values:

CODE	DESCRIPTION
AND	All must apply/must be used
OR	Any can apply/can be used

4. Appendix DD – SIG Segment Variable Modifier Values

Values:

CODE	DESCRIPTION
AND	All must apply/must be used
OR	Any can apply/can be used
TO	A range

B. ASC X12 DATA ELEMENTS

The following X12 data elements are used in the SCRIPT Standard.

47Ø9 - Agency Qualifier, coded *(X12 DE 559)*

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Refer to X-12 DE 559.	an..3	S	

Values:

CODE	DESCRIPTION	Field Limitations
AM	American Medical Association	Used only in SCRIPT Standard Versions 5.Ø through 1Ø.4. Value was deleted for use in higher versions of this standard.
DE	Drug Enforcement Agency	Used only in SCRIPT Standard Versions 5.Ø through 1Ø.4. Value was deleted for use in higher versions of this standard.
DR	National Wholesale Druggist Association	Used only in SCRIPT Standard Versions 5.Ø through 1Ø.4. Value was deleted for use in higher versions of this standard.
HC	HCFA	Used only in SCRIPT Standard Versions 5.Ø through 1Ø.4. Value was deleted for use in higher versions of this standard.
A	Health Care Provider Taxonomy code set - The Health Care Provider Taxonomy code set includes specialty categories for individuals, Groups of individuals, and non-individuals.	Value may be used in SCRIPT Standard Version 1Ø.5 or greater but not in lower versions.

1131 – Code List Qualifier –Communication Number - PVD, PTT, COO Segment (X12 DE 365)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifies the Communication Number.	an..3	S	

Values:

CODE	DESCRIPTION
SEE SECTION II - APPENDIX K – VALUES FOR COMMUNICATION CODES	

1131 – Code List Qualifier – Diagnosis Code Qualifier (Secondary) - DRU Segment (X12 DE 235)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifies the code list used for the secondary diagnosis.	an..3	S	

Values:

CODE	DESCRIPTION
DX	International Classification of Diseases-9- Clinical Modifications-Diagnosis
ABF	International Classification of Diseases-1Ø- Clinical Modifications

1131 – Code List Qualifier – Drug Form - DRU Segment (X12 DE 133Ø)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Drug form, in a code. Dosage form code.	an..3	S	Used only in SCRIPT Standard Versions 5.Ø through 1Ø.4. Field was deleted for use in higher versions of this standard. For SCRIPT Standard Version 1Ø.5 and higher use 7991 - Source Code List and 7992 Item Form Code in Section III-A

Values:

Ø1	Combination Forms
Ø2	Test Kits
Ø3	Contraceptive Devices
Ø4	Devices
Ø5	Patch or Disc
Ø6	Chewable (candy) Bar
Ø7	Dosepak
1Ø	Tablet
11	Enteric Coated Tablet
12	Sustained Release Tablet
13	Buccal or Sublingual Tablet
14	Chewable Tablet
15	Soluble Tablet
16	Tablet Unspecified
2Ø	Capsule
21	Sustained Release Capsule
22	Capsule Unspecified
23	Tablet 21 Day Supply
24	Tablet 28 Day Supply
25	Enteric Coated Capsule
3Ø	Lozenge or Troche
31	Internal Powder
32	Chewing Gum
33	Granules
34	Swabs
4Ø	Injection
41	Sustained Release Injection
42	Injectable Unspecified
43	Injectable Lyophilized Powder
5Ø	Opthalmic Liquid
52	Opthalmic or Otic
53	Ophthalmic Liquid (Compliance Cap)
6Ø	Elixir
61	Suspension
62	Syrup
63	Solution
64	Emulsion
65	Drops

66	Pediatric Liquid
67	Liquid
68	Oral, Liquid, and Sustained Release
69	Rectal Cream or Ointment
7Ø	Rectal Suppository
71	Vaginal Suppository
72	Vaginal Tablet
73	Vaginal Cream
74	Vaginal Foam
75	Urethral Suppository
76	Enema
77	Douche
78	Vaginal Ointment
79	Contraceptive Sponge
8Ø	External Ointment
81	External Cream
82	Dental Product
83	Aerosol Powder
84	Aerosol Spray
85	External Liquid
86	External Powder
87	Dental Mouth Rinse
88	Inhalant (Refill Canister Only)
89	Not Used
9Ø	Irrigant
91	Gargle
92	Throat Spray and Swabs
93	Nasal
94	Inhalant
95	Otic
96	Soap
97	Stick
98	Dressing or Bandage
99	Miscellaneous Unspecified
1ØØ	Aerosol
1Ø1	Aerosol with adapter
1Ø2	Bar
1Ø3	Capsule, sprinkle

1Ø4	Capsule, extended release
1Ø5	Concentrate
1Ø6	Cream
1Ø7	Cream with applicator
1Ø8	Crystal
1Ø9	Not used
111	Film
112	Film, extended release
113	Flakes
114	Foam
115	Foam with applicator
116	Gel
117	Gel forming solution
118	Gel with applicator
119	Granule for reconstitution
12Ø	Granule, effervescent
121	Granule, extended release
122	Gum
123	Implant
124	Insert
125	Kit
126	Leaves
127	Lollipop
128	Lotion
129	Lozenge
13Ø	Oil
131	Ointment
132	Ointment w/applicator
133	Pad
134	Paste
135	Pellet
136	Powder
137	Powder for injection
138	Powder for reconstitution
139	Ring
14Ø	Shampoo
141	Spirit
142	Sponge
143	Spray
144	Suppository (ies)
145	Not Used
146	Suspension, extended release
147	Tablet, chewable
148	Tablet, coated particles
149	Tablet, disintegrating
15Ø	Tablet, effervescent
151	Tablet, extended release
152	Tampon
153	Tape
154	Tar
155	Test
156	Tincture
157	Wafer
158	Wax
159	Troche
16Ø	Aerosol Solution
161	Extract
162	Nebulize Solution
163	Powder Effervescent
164	Strip

Alphabetic Listing:

CODE	DESCRIPTION
1ØØ	Aerosol
83	Aerosol Powder
16Ø	Aerosol Solution
84	Aerosol Spray
1Ø1	Aerosol with adapter
1Ø2	Bar
13	Buccal or Sublingual Tablet
2Ø	Capsule
22	Capsule Unspecified
1Ø4	Capsule, extended release
1Ø3	Capsule, sprinkle
Ø6	Chewable (candy) Bar
14	Chewable Tablet
32	Chewing Gum
Ø1	Combination Forms
1Ø5	Concentrate
Ø3	Contraceptive Devices
79	Contraceptive Sponge
1Ø6	Cream
1Ø7	Cream with applicator
1Ø8	Crystal
87	Dental Mouth Rinse

CODE	DESCRIPTION
82	Dental Product
Ø4	Devices
Ø7	Dosepak
77	Douche
98	Dressing or Bandage
65	Drops
6Ø	Elixir
64	Emulsion
76	Enema
25	Enteric Coated Capsule
1Ø9	Not used
11	Enteric Coated Tablet
81	External Cream
85	External Liquid
8Ø	External Ointment
86	External Powder
161	Extract
89	Not used
111	Film
112	Film, extended release
113	Flakes
114	Foam
115	Foam with applicator
91	Gargle
116	Gel
117	Gel forming solution
118	Gel with applicator
119	Granule for reconstitution
12Ø	Granule, effervescent
121	Granule, extended release
33	Granules
122	Gum
123	Implant
94	Inhalant
88	Inhalant (Refill Canister Only)
43	Injectable Lyophilized Powder
42	Injectable Unspecified
4Ø	Injection
124	Insert
31	Internal Powder
9Ø	Irrigant
125	Kit
126	Leaves
67	Liquid
127	Lollipop

CODE	DESCRIPTION
128	Lotion
129	Lozenge
3Ø	Lozenge or Troche
99	Miscellaneous Unspecified
93	Nasal
162	Nebulize Solution
13Ø	Oil
131	Ointment
132	Ointment w/applicator
53	Ophthalmic Liquid (Compliance Cap)
5Ø	Ophthalmic Liquid
52	Ophthalmic or Otic
68	Oral, Liquid, and Sustained Release
95	Otic
133	Pad
134	Paste
Ø5	Patch or Disc
66	Pediatric Liquid
135	Pellet
136	Powder
163	Powder Effervescent
137	Powder for injection
138	Powder for reconstitution
69	Rectal Cream or Ointment
7Ø	Rectal Suppository
139	Ring
14Ø	Shampoo
96	Soap
15	Soluble Tablet
63	Solution
141	Spirit
142	Sponge
143	Spray
97	Stick
164	Strip
144	Suppository(ies)
61	Suspension
145	Not used
146	Suspension, extended release
21	Sustained Release Capsule
41	Sustained Release Injection
12	Sustained Release Tablet
34	Swabs
62	Syrup
1Ø	Tablet

CODE	DESCRIPTION
23	Tablet 21 Day Supply
24	Tablet 28 Day Supply
16	Tablet Unspecified
147	Tablet, chewable
148	Tablet, coated particles
149	Tablet, disintegrating
15Ø	Tablet, effervescent
151	Tablet, extended release
152	Tampon
153	Tape
154	Tar
155	Test

CODE	DESCRIPTION
Ø2	Test Kits
92	Throat Spray and Swabs
156	Tincture
159	Troche
75	Urethral Suppository
73	Vaginal Cream
74	Vaginal Foam
78	Vaginal Ointment
71	Vaginal Suppository
72	Vaginal Tablet
157	Wafer
158	Wax

1131 – Code List Qualifier – used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Drug strength qualifier. Unit or Basis for Measurement Code. Also used for measurement unit qualifier.	an..3	S	Used only in SCRIPT Standard Versions 5.Ø through 1Ø.4. Field was deleted for use in higher versions of this standard. For SCRIPT Standard Version 1Ø.5 and higher use 7991 - Source Code List and 7993 Item Strength Code in Section III-A

Values:

CODE	DESCRIPTION
ØØ	Not Specified
1Ø	Group
12	Packet
14	Shot
1N	Count
22	Decliter per Gram
23	Grams per Cubic Centimeter
3F	Kilograms Per Liter of Product
4Ø	Milliliter per Second
41	Milliliter per Minute
4E	2Ø-Pack
4G	Microliter
4M	Milligrams per Hour
58	Net Kilograms
6Ø	Percent Weight
93	Calories Per Gram
AF	Centigram
AM	Ampoule
AQ	Anti-hemophilic Factor (AHF) Units
AR	Suppository
AS	Assortment
AU	Ocular Insert System

CODE	DESCRIPTION
AV	Capsule
AW	Powder-Filled Vials
AY	Assembly
BG	Bag
BI	Bar
BO	Bottle
BX	Box
C3	Centiliter
C5	Cost
C7	Centipoise (CPS)
C8	Cubic Decimeter
CC	Cubic Centimeter
CH	Container
CI	Cubic Inches
CM	Centimeter
CQ	Cartridge
CS	Cassette
CT	Carton
CU	Cup
D5	Kilogram Per Square Centimeter
DA	Days
DB	Dry Pounds

CODE	DESCRIPTION
DD	Degree
DF	Dram
DG	Decigram
DI	Dispenser
DJ	Decagram
DL	Deciliter
E8	Inches, Decimal – Actual
EA	Each
EC	Each per Month
EP	Eleven Pack
EQ	Equivalent Gallons
F2	International Unite
F3	Equivalent
F4	Minim
F5	MOL
FG	Transdermal Patch
FH	Micromolar
FO	Fluid Ounce
FZ	Fluid Ounce (Imperial)
GA	Gallon
GB	Gallons/Day
GC	Grams per 1ØØ Grams
GE	Pounds per Gallon
GF	Grams per 1ØØ Centimeters
GH	Half Gallon
GI	Imperial Gallons
GJ	Grams per Milliliter
GK	Grams per Kilogram
GL	Grams per Liter
GM	Grams per Sq. Meter
GO	Milligrams per Square Meter
GP	Milligrams per Cubic Meter
GQ	Micrograms per Cubic Meter
GR	Gram
GX	Grain
H2	Half Liter
H4	Hectoliter
HP	Millimeter H2O
HR	Hours
HT	Half Hour
IH	Inhaler
IN	Inch
JR	Jar
KC	Kilograms per Cubic Meter
KD	Kilograms Decimal

CODE	DESCRIPTION
KE	Keg
KG	Kilogram
KI	Kilograms/Millimeter Width
KM	Kilograms per Square Meter, Kilograms, Decimal
KT	Kit
KW	Kilograms per Millimeter
KX	Milliliters per Kilogram
L2	Liters Per Minute
LB	Pound
LQ	Liters Per Day
LT	Liter
M1	Milligrams per Liter
M2	Millimeter – Actual
M7	Micro Inch
MC	Microgram
ME	Milligram
ML	Milliliter
MM	Millimeter
MO	Months
MR	Meter
MS	Square Millimeter
MX	Mixed
MY	Millimeter – Average
MZ	Millimeter – minimum
N1	Pen Calories
N4	Pen Grams (Protein)
N9	Cartridge Needle
NA	Milligrams per Kilogram
NX	Parts Per Thousand
OP	Two Pack
OZ	Ounce – Av
P1	Percent
P3	Three Pack
P4	Four-pack
P5	Five-pack
P6	Six pack
P7	Seven pack
P8	Eight-pack
P9	Nine pack
PH	Pack
PK	Package
PR	Pair
PT	Pint
PV	Half Pint

CODE	DESCRIPTION
PX	Pint, Imperial
PY	Peck, Dry Imperial
Q2	Pint U.S. Dry
QK	Quarter Kilogram
QS	Quart, Dry U.S.
QT	Quart
QU	Quart, Imperial
S1	Semester
S2	Trimester
SR	Strip
SZ	Syringe
T2	Thousandths of an Inch
TB	Tube
TP	Ten-pack
TY	Tray
U1	Treatments
U2	Tablet
U3	Ten
U5	Two Hundred Fifty
UM	Million Units
UN	Unit
UP	Troche
UQ	Wafer
UR	Application
US	Dosage Form

CODE	DESCRIPTION
UT	Inhalation
UU	Lozenge
UV	Percent Topical Only
UW	Milliequivalent
UX	Dram (Minim)
VI	Vial
VP	Percent Volume
VS	Visit
WW	Milliliters of Water
X4	Drop
X9	Portion
Y2	Tablespoon
Y3	Teaspoon
Y4	Tub
Y5	Applicatorful
Y6	Dose(s)
Y7	Gum
Y8	Inhalation(s)
Y9	Puff(s)
Y1Ø	Scoop(s)
Y11	Spray(s)
Y12	Thin layer
YR	Years
ZZ	Mutually Defined

Alphabetic Listing:

CODE	DESCRIPTION
4E	2Ø-Pack
AM	Ampoule
AQ	Anti-hemophilic Factor (AHF) Units
UR	Application
Y5	Applicatorful
AY	Assembly
AS	Assortment
BG	Bag
BI	Bar
BO	Bottle
BX	Box
93	Calories Per Gram
AV	Capsule
CT	Carton
CQ	Cartridge
N9	Cartridge Needle
CS	Cassette

CODE	DESCRIPTION
AF	Centigram
C3	Centiliter
CM	Centimeter
C7	Centipoise (CPS)
CH	Container
C5	Cost
1N	Count
CC	Cubic Centimeter
C8	Cubic Decimeter
CI	Cubic Inches
CU	Cup
DA	Days
DJ	Decagram
DG	Decigram
DL	Deciliter
22	Deciliter per Gram
DD	Degree

CODE	DESCRIPTION
DI	Dispenser
US	Dosage Form
Y6	Dose(s)
DF	Dram
UX	Dram (Minim)
X4	Drop
DB	Dry Pounds
EA	Each
EC	Each per Month
P8	Eight-pack
EP	Eleven Pack
F3	Equivalent
EQ	Equivalent Gallons
P5	Five-pack
FO	Fluid Ounce
FZ	Fluid Ounce (Imperial)
P4	Four-pack
GA	Gallon
GB	Gallons/Day
GX	Grain
GR	Gram
GF	Grams per 1ØØ Centimeters
GC	Grams per 1ØØ Grams
23	Grams per Cubic Centimeter
GK	Grams per Kilogram
GL	Grams per Liter
GJ	Grams per Milliliter
GM	Grams per Sq. Meter
1Ø	Group
Y7	Gum
GH	Half Gallon
HT	Half Hour
H2	Half Liter
PV	Half Pint
H4	Hectoliter
HR	Hours
GI	Imperial Gallons
IN	Inch
E8	Inches, Decimal – Actual
UT	Inhalation
Y8	Inhalation(s)
IH	Inhaler
F2	International Unite
JR	Jar
KE	Keg

CODE	DESCRIPTION
KG	Kilogram
D5	Kilogram Per Square Centimeter
KD	Kilograms Decimal
KC	Kilograms per Cubic Meter
3F	Kilograms Per Liter of Product
KW	Kilograms per Millimeter
KM	Kilograms per Square Meter, Kilograms, Decimal
KI	Kilograms/Millimeter Width
KT	Kit
LT	Liter
LQ	Liters Per Day
L2	Liters Per Minute
UU	Lozenge
MR	Meter
M7	Micro Inch
MC	Microgram
GQ	Micrograms per Cubic Meter
4G	Microliter
FH	Micromolar
UW	Milliequivalent
ME	Milligram
GP	Milligrams per Cubic Meter
4M	Milligrams per Hour
NA	Milligrams per Kilogram
M1	Milligrams per Liter
GO	Milligrams per Square Meter
ML	Milliliter
41	Milliliter per Minute
4Ø	Milliliter per Second
WW	Milliliters of Water
KX	Milliliters per Kilogram
MM	Millimeter
M2	Millimeter – Actual
MY	Millimeter – Average
MZ	Millimeter – minimum
HP	Millimeter H2O
UM	Million Units
F4	Minim
MX	Mixed
F5	MOL
MO	Months
ZZ	Mutually Defined
58	Net Kilograms
P9	Nine pack

CODE	DESCRIPTION
ØØ	Not Specified
AU	Ocular Insert System
OZ	Ounce – Av
PH	Pack
PK	Package
12	Packet
PR	Pair
NX	Parts Per Thousand
PY	Peck, Dry Imperial
N1	Pen Calories
N4	Pen Grams (Protein)
P1	Percent
UV	Percent Topical Only
VP	Percent Volume
6Ø	Percent Weight
PT	Pint
Q2	Pint U.S. Dry
PX	Pint, Imperial
X9	Portion
LB	Pound
GE	Pounds per Gallon
AW	Powder-Filled Vials
Y9	Puff(s)
QT	Quart
QS	Quart, Dry U.S.
QU	Quart, Imperial
QK	Quarter Kilogram
Y1Ø	Scoop(s)
S1	Semester
P7	Seven pack
14	Shot

CODE	DESCRIPTION
P6	Six pack
Y11	Spray(s)
MS	Square Millimeter
SR	Strip
AR	Suppository
SZ	Syringe
Y2	Tablespoon
U2	Tablet
Y3	Teaspoon
U3	Ten
TP	Ten-pack
Y12	Thin layer
T2	Thousandths of an Inch
P3	Three Pack
FG	Transdermal Patch
TY	Tray
U1	Treatments
S2	Trimester
UP	Troche
Y4	Tub
TB	Tube
U5	Two Hundred Fifty
OP	Two Pack
UN	Unit
VI	Vial
VS	Visit
UQ	Wafer
YR	Years

1131 – Code List Qualifier – used for 6Ø63 - Quantity Qualifier (X12 DE 355)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Used for Quantity Qualifier.	an..3	S	Effective SCRIPT Standard Version 1Ø.1 or greater, the following list of values are to be used. Used only in SCRIPT Standard Versions 5.Ø through 1Ø.4. Field was deleted for use in higher versions of this standard. For SCRIPT Standard Version 1Ø.5 and higher use 7991 - Source Code List and 7994 Potency Unit Code in Section III-A

Values:

CODE	DESCRIPTION
BG	Bag

CODE	DESCRIPTION
BO	Bottle
BX	Box
AV	Capsule
CQ	Cartridge
CH	Container
X4	Drop
FO	Fluid Ounce
GR	Gram
IH	Inhaler
F2	International Unite
KT	Kit
LT	Liter
MR	Meter
UU	Lozenge
ME	Milligram
ML	Milliliter
UM	Million Units
ZZ	Mutually Defined
FO	Fluid Ounce
ØØ	Not Specified
PH	Pack
12	Packet
PT	Pint
AR	Suppository
SZ	Syringe
Y2	Tablespoon
U2	Tablet
Y3	Teaspoon
FG	Transdermal Patch
TB	Tube
UN	Unit
VI	Vial

1131 – Code List Qualifier – Quantity Qualifier - DRU Segment (X12 DE 673)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Quantity qualifier. X12 DE 673	an..3	S	

Values:

CODE	DESCRIPTION
38	Original Quantity
4Ø	Remaining Quantity
87	Quantity Received
QS	Quantity sufficient as determined by the dispensing pharmacy. Quantity to be based on established dispensing protocols between the prescriber and pharmacy/pharmacist.

3Ø55 - Code List Responsibility Agency (X12 DE 235)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
The code list defining the Item Number (Drug Number).	an..3	S	

Values:

CODE	DESCRIPTION
ND	NDC
UP	UPC
MF	MFG

2ØØ5 - Date/Time/Period Qualifier (X12 DE 432)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualification of Date/Time field 238Ø.	an..3	S	

Values:

CODE	DESCRIPTION
Ø6	Sold Date - The date the product was sold by the pharmacy.
Ø7	Effective Date (Begin)
35	Delivered on This Date (Date prescription received at facility)
36	Expiration Date
74	Delivery date/time, requested for (prior to and including) Delivery is requested to happen prior to or including the given date
85	Date Issued (Written Date)
LD	Last Demand (Last Fill)
BE	Validated (Date reviewed at facility) = The date when material obligations were verified
PE	Period End (End)
ZDS	Days Supply

47Ø3 - Insurance Type, coded (X12 DE 1138)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates the insurance type.	an..3	S	Field and values may be used in SCRIPT Standard Version 1Ø.1 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
P	Primary
S	Secondary
T	Tertiary
U	Unknown
PP	Private Pay

6311 - Measurement Dimension, coded (Values when referencing X12 DE 738)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifies the Measurement value.	an..3	S	

Values:

CODE	DESCRIPTION
HT	Height
WG	Weight
ZZS	Blood Pressure – Systolic
ZZD	Blood Pressure – Diastolic

Note:
6311 - Measurement Dimension, coded (*Values when referencing SNOMED, use SNOMED code list* at http://www.nlm.nih.gov/research/umls/ or www.snomed.org)
6311 - Measurement Dimension, coded (*Values when referencing LOINC, use LOINC code list* at http://www.regenstrief.org/loinc/)

6411 – Measurement Unit Qualifier (X12 DE 355)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Unit of Measure. See 1131 - Code List Qualifier - used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier, and 6Ø63 - Quantity Qualifier (X12 DE 355).	an..3	S	

47Ø5 - Provider Coded (X12 DE 1221)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Defines the usage of this segment. Used to define the provider.	an..3	S	

Values:

CODE	DESCRIPTION		CODE	DESCRIPTION
LISTING:			**ALPHABETIC LISTING:**	
H	Hospital		AD	Admitting
R	Rural Health Clinic		AS	Assistant Surgeon
AD	Admitting		AT	Attending
AS	Assistant Surgeon		BI	Billing
AT	Attending		BS	Billing Service
BI	Billing		CO	Consulting
BS	Billing Service		CV	Covering
CO	Consulting		HH	Home Health Care
CV	Covering		H	Hospital
HH	Home Health Care		LA	Laboratory
LA	Laboratory		ON	On Staff
ON	On Staff		OP	Operating
OP	Operating		OR	Ordering
OR	Ordering		OT	Other Physician

CODE	DESCRIPTION		CODE	DESCRIPTION
OT	Other Physician		PT	Pay To
P1	Pharmacist		PE	Performing
P2	Pharmacy		P1	Pharmacist
PC	Primary Care Physician		P2	Pharmacy
PE	Performing		PC	Primary Care Physician
PT	Pay To		PU	Purchasing
PU	Purchasing		RF	Referring
RF	Referring		RP	Reporting Provider
RP	Reporting Provider		R	Rural Health Clinic
SB	Submitting		SK	Skilled Nursing Facility
SK	Skilled Nursing Facility		SB	Submitting
SU	Supervising		SU	Supervising

47Ø7 - Provider Specialty, coded (X12 DE 1222)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Refer to X-12 DE 1222 or to the list specified by the value contained in 47Ø9 Agency Qualifier, coded.	an..3	S	Used only in SCRIPT Standard Versions 5.Ø through 1Ø.4. Field was deleted for use in higher versions of this standard. For SCRIPT Standard Version 1Ø.5 and higher use 799Ø - Provider Specialty code in Section III-A

Values:

CODE	DESCRIPTION
See Section II - APPENDIX J – VALUES FOR SPECIALTY CODES	

6Ø63 - Quantity Qualifier (X12 DE 355)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifies the Measurement value. See 1131 - Code List Qualifier - used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier, and 6Ø63 - Quantity Qualifier (X12 DE 355).	an..3	S	

1153 – Reference Qualifier (X12 DE 128)

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Defines the Reference number, field 1154. Used to define different qualifiers for numbers, values as appropriate for usage.	an..3	S	

Values:

CODE	DESCRIPTION
94	Pharmacy or Prescriber File ID
ØB	State License Number
1C	Medicare Number
1D	Medicaid Number

CODE	DESCRIPTION
1E	Dentist License Number
1G	UPIN
1J	Facility ID Number = ID number assigned by the LTC Facility to the patient
1M	PPO Number
2U	Payer Identification Number
ADI	Processor Identification Number – Processor Control Number assigned by the processor.
BO	BIN Location Number
C1	Commercial
EA	Medical Record Identification Number (EHR) = A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records
EJ	Patient Account Number (ID assigned by the CPOE system) = A unique number assigned to each patient by the provider of service to facilitate retrieval of individual case records tracking of claims submitted to a payer and posting of payment
D3	NCPDP Provider ID Number
DH	DEA Number
G1	Prior Authorization
HI	HIN
HPI	National Provider ID
IP	Individual Policy Number
NC	Secondary Coverage Company Number
NF	National Association of Insurance Commissioner's Code
PD	Promotion Number (Sample RX)
SY	Social Security Number
ZZ	Mutually Defined

ALPHABETIC LISTING:

CODE	DESCRIPTION
ADI	Processor Identification Number – Processor Control Number assigned by the processor.
BO	BIN Location Number
C1	Commercial
DH	DEA Number
1E	Dentist License Number
1J	Facility ID Number = ID number assigned by the LTC Facility to the patient
HI	HIN
IP	Individual Policy Number
1D	Medicaid Number
EA	Medical Record Identification Number (EHR) = A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records
1C	Medicare Number
ZZ	Mutually Defined
NF	National Association of Insurance Commissioner's Code
HPI	National Provider ID (NPI)

CODE	DESCRIPTION
D3	NCPDP Provider ID Number
EJ	Patient Account Number (ID assigned by the CPOE system) = A unique number assigned to each patient by the provider of service to facilitate retrieval of individual case records tracking of claims submitted to a payer and posting of payment
2U	Payer Identification Number
94	Pharmacy or Prescriber File ID
1M	PPO Number
G1	Prior Authorization
PD	Promotion Number (Sample RX)
NC	Secondary Coverage Company Number
SY	Social Security Number
ØB	State License Number
1G	UPIN

C. UN/EDIFACT DATA ELEMENTS

The following UN/EDIFACT data elements are used in the SCRIPT Standard.

2379 - Date/Time/Period Format Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Defines the date format used.	an..3	S	

Values:

CODE	DESCRIPTION
1Ø2	Date CCYYMMDD
2Ø3	CCYYMMDDHHMM = Calendar date including time with minutes: C=Century; Y=Year; M=Month; D=Day; H=Hour; M=Minutes.
8Ø4	Quantity of Days

77Ø1 - Service Type, coded

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Medication list contains all current **medication orders** as of the current date and time of the response, for the patient indicated. Current status is determined by the point of care responder. “Current” is medication orders which have not been discontinued.	an..3	S	Field and values may be used in SCRIPT Standard Version 1Ø.4 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
C	Current Medication Orders - The contents are limited to **medication orders** that are current (within their Start and Stop dates, or on-or-after the Start date if open-ended).

7895 – Source Qualifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Qualifies the Source Description.	an..3	S	Field and values may be used in SCRIPT Standard Version 1Ø.3 or greater but not in lower versions.

Values:

CODE	DESCRIPTION
P2	Pharmacy - A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
PC	Prescriber - A licensed entity that prescribes prescription drugs and provides professional medical services, such as clinical services respective to the prescribing function
PY	Payer - Entity that processes the data submitted by a provider of pharmacy services for the purpose of receiving eligibility and coverage determination and/or payment.

ØØ35 – Test Indicator

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Indicates whether the transaction is test or live	n1	S	

Values:

CODE	DESCRIPTION
1	Test
Any other value	Live

2Ø29 - Time Zone Identifier

Definition of Field	Field Format	Standard/Version Formats	Field Limitations
Defines the time zone used by the sender.	an..3	S	

Values:

CODE	DESCRIPTION
UT	Universal Time Coordinate

IV. PUBLICATION RELEASE MODIFICATIONS

A. PUBLICATION RELEASE MAY 2ØØ4

THIS IS THE FIRST PUBLICATION OF THE ECL FOR USE BY THE TÉLÉCOMMUNICATION STANDARD VERSION 9.Ø AND SCRIPT STANDARD VERSION 5.Ø

1. Section II

FIELD	MODIFICATION
532-FW - Database Indicator	Value Change: Value 2 from Medi-Span to Medi-Span Product Line
492-WE – Diagnosis Code Qualifier	Value Change: Value 2 from International Classification of Diseases (ICD1Ø) to International Classification of Diseases-1Ø-Clinical Modifications (ICD-1Ø-CM); Value 6 from First DataBank MDDB Product Line to Medi-Span Product Line Diagnosis Code Deleted note at end of table: "Note:MDDB is not an acronym"
6Ø1-19 - Product Code Qualifier	Value Change: Value 2 from First DataBank Generic Product Identifier (GPI) to Medi-Span Product Line Generic Product Identifier (GPI); Value 4 from First DataBank Drug Descriptor Identifier (DDID) to Medi-Span Product Line Drug Descriptor ID (DDID)
6Ø1-26 - Therapeutic Class Code Qualifier	Value Change: Value 2 from First DataBank Generic Product Identifier (GPI) to Medi-Span Product Line Generic Product Identifier (GPI) ; Value 4 from First DataBank Drug Descriptor Identifier (DDID) to Medi-Span Product Line Drug Descriptor ID (DDID)
436-E1 – Product/Service ID Qualifier **Appendix B**	Value Change: Value 14 from First DataBank Generic Product Identifier (GPI) to Medi-Span Product Line Generic Product Identifier (GPI) ; Value 17 from First DataBank Drug Descriptor Identifier (DDID) to Medi-Span Product Line Drug Descriptor ID (DDID); Value 21 from International Classification of Diseases (ICD1Ø) to International Classification of Diseases-1Ø-Clinical Modifications (ICD-1Ø-CM); Value 22 from First DataBank MDDB Product Line Diagnosis Code to Medi-Span Product Line Diagnosis Code Value Added: Value "27= International Classification of Diseases-1Ø-Procedure Coding System (ICD-1Ø-PCS)." Deleted note at end of table: "Note:MDDB is not an acronym"

2. Section III

FIELD	MODIFICATION
1153 – Reference Qualifier– Generic Database, Prior Authorization - DRU Segment	Values Changed: Value MD from First DataBank Drug Descriptor Identifier (DDID) to Medi-Span Product Line DDID; Value MG from First DataBank MDDB Product Line Generic Product Identifier (GPI) to Medi-Span Generic Product Identifier (GPI) Deleted note at end of table: "Note:MDDB is not an acronym"
1131 – Code List Qualifier – Diagnosis Code Qualifier (Primary) - DRU Segment	Value Changed: Value M from First DataBank MDDB Product Line to Medi-Span Product Line Deleted note at end of table: "Note:MDDB is not an acronym"
1131 – Code List Qualifier – Diagnosis Code Qualifier (Primary) - DRU Segment	Value Changed: Value "ID=ICD-9" to "DX="International Classification of Diseases-9- Clinical Modifications-Diagnosis (ICD-9-CM-Diagnosis)" Value Added: Value "ABF= International Classification of Diseases-1Ø- Clinical Modifications (ICD-1Ø-CM)"
1131 – Code List Qualifier – Response Code - RES Segment	Value Added: Value "AN=Prescriber not associated with this practice or location."
9Ø15- Status Type, coded	Value Added: Value "Ø1Ø=Successful – accepted by ultimate receiver"
1131 – Code List Qualifier –	Value Changed: Value "ID=ICD-9" to "DX=International Classification of

Diagnosis Code Qualifier (Secondary) - DRU Segment (X12 DE 235)	Diseases-9-Clinical Modifications-Diagnosis (ICD-9-CM-Diagnosis)" Value Added: Value "ABF= International Classification of Diseases-1Ø- Clinical Modifications (ICD-1Ø-CM)"

B. PUBLICATION RELEASE AUGUST 2ØØ4

1. Section II

FIELD	MODIFICATION
511-FB Reject Code (APPENDIX A – TELECOMMUNICATION REJECT CODES)	Value Added: Value "4W = Must Fill Through Specialty Pharmacy"
466-EZ Prescriber ID Qualifier	Values Defined: Values Ø1 – 13 were defined.
468-2E Primary Care Provider ID Qualifier	Values Defined: Values Ø1 – 13 were defined.
2Ø2-B2 Service Provider ID Qualifier	Values Defined: Values Ø1 – 13 were defined.

C. PUBLICATION RELEASE OCTOBER 2ØØ4

1. Section II

FIELD	MODIFICATION
511-FB Reject Code (APPENDIX A – TELECOMMUNICATION REJECT CODES)	Value modified: Value 7Ø – Added field 489 to Field Number Possibly in Error column

2. Section III

FIELD	MODIFICATION
4343 – Message Function, coded	Values Added: Value P = Prior Authorization Required
1131 – Code List Qualifier – Response Code - RES Segment	Value Added: Value AO = No attempt will be made to obtain Prior Authorization

D. PUBLICATION RELEASE JANUARY 2ØØ5

1. Section III

FIELD	MODIFICATION
1131 – Code List Qualifier – Response Code - RES Segment	Value Added: Value AP = Request already responded to by other means (e.g. phone or fax)

E. PUBLICATION RELEASE MAY 2ØØ5

1. Section II

FIELD	MODIFICATION
384-4X Patient Residence	New Field with values (May be used in Telecommunication Standard Version B.Ø

	or greater but not in lower versions.)
3Ø7-C7 Place of Service	Name change from Patient Location with all new values (May be used in Telecommunication Standard Version B.Ø or greater but not in lower versions.)
511-FB Reject Code (APPENDIX A – TELECOMMUNICATION REJECT CODES)	Added heading to Appendix; Values added, modified, and deleted (see following 2 tables)

New Codes Added:

New Reject Codes for Field 511-FB Reject Code

Field ID	Reject Code	Field Name	New Reject Explanation
1Ø2-A2	1R	Version/Release Number	Version/Release Not Supported
1Ø3-A3	1S	Transaction Code	Transaction Code/Type Not Supported
1Ø4-A4	1T	Processor Control Number	PCN Must Contain Processor/Payer Assigned Value
1Ø9-A9	1U, 1V, 1W	Transaction Count	Transaction Count Does Not Match Number of Transactions, Multiple Transactions Not Supported, Multi-Ingredient Compound Must Be A Single Transaction
11Ø-AK	1X	Software Vendor/Certification ID	Vendor Not Certified For Processor/Payer
111-AM	1Y, 1Z, 6G-2X	Segment Identification	Claim Segment Required For Adjudication, Clinical Segment Required For Adjudication, Coordination Of Benefits/Other Payments Segment Required For Adjudication, Coupon Segment Required For Adjudication, Insurance Segment Required For Adjudication, Patient Segment Required For Adjudication, Pharmacy Provider Segment Required For Adjudication, Prescriber Segment Required For Adjudication, Pricing Segment Required For Adjudication, Prior Authorization Segment Required For Adjudication, Worker's Compensation Segment Required For Adjudication, Transaction Segment Required For Adjudication, Compound Segment Required For Adjudication, Compound Segment Incorrectly Formatted, Multi-ingredient Compounds Not Supported, DUR/PPS Segment Required For Adjudication, DUR/PPS Segment Incorrectly Formatted
2Ø1-B1	6Y, 6Z, 7A	Service Provider ID	Not Authorized To Submit Electronically, Provider Not Eligible To Perform Service/Dispense Product, Provider Does Not Match Authorization On File
2Ø2-B2	7B	Service Provider ID Qualifier	Service Provider ID Qualifier Value Not Supported For Processor/Payer
3Ø4-C4	7D, 7F	Date Of Birth	Non-Matched DOB, Future Date Not Allowed For DOB
3Ø5-C5	7H	Patient Gender Code	Non-Matched Gender Code
3Ø6-C6	7J	Patient Relationship Code	Patient Relationship Code Not Supported
3Ø7-C7	4Z	Place of Service	Place of Service Not Support By Plan

New Reject Codes for Field 511-FB Reject Code			
Field ID	**Reject Code**	**Field Name**	**New Reject Explanation**
3Ø8-C8	7K, 7M	Other Coverage Code	Discrepancy Between Other Coverage Code And Other Payer Amt., Discrepancy Between Other Coverage Code And Other Coverage Information On File
331-CX	7N	Patient ID Qualifier	Patient ID Qualifier Submitted Not Supported
337-4C	7P	Coordination Of Benefits/Other Payments Count	Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers
339-6C	7Q	Other Payer ID Qualifier	Other Payer ID Qualifier Not Supported
341-HB	7R	Other Payer Amount Paid Count	Other Payer Amount Paid Count Exceeds Number of Supported Groupings
342-HC	7S	Other Payer Amount Paid Qualifier	Other Payer Amount Paid Qualifier Not Supported
344-HF	7T	Quantity Intended To Be Dispensed	Quantity Intended To Be Dispensed Required For Partial Fill Transaction
345-HG	7U	Days Supply Intended To Be Dispensed	Days Supply Intended To Be Dispensed Required For Partial Fill Transaction
384-4X	4X	Patient Residence	M/I Patient Residence
384-4X	4Y	Patient Residence	Patient Residence not supported by plan
4Ø3-D3	7V, 7W	Fill Number	Duplicate Refills, Refills Exceed allowable Refills
4Ø5-D5	7X	Days Supply	Days Supply Exceeds Plan Limitation
4Ø6-D6	7Y, 7Z, 8A, 8B, 8D	Compound Code	Compounds Not Covered, Compound Requires Two Or More Ingredients, Compound Requires At Least One Covered Ingredient, Compound Segment Missing On A Compound Claim, Compound Segment Present On A Non-Compound Claim
4Ø7-D7	8G, 8H, 8J	Product/Service ID	Primary Product In A Compound Claim Is Not Zero, Product/Service Only Covered On Compound Claim, *Incorrect Product/Service ID For Processor/Payer (*add reference to field 489-Compound Product ID)
4Ø8-D8	8K	Dispense As Written (DAW)/Product Selection Code	DAW Code Not Supported
4Ø9-D9	8M	Ingredient Cost Submitted	Sum Of Compound Ingredient Costs Does Not Equal Ingredient Cost Submitted
414-DE	8N, 8P	Date Prescription Written	Future Date Prescription Written Not Allowed, Date Written Different On Previous Filling
415-DF	8Q	Number Of Refills Authorized	Excessive Refills Authorized
42Ø-DK	8R	Submission Clarification Code	Submission Clarification Code Not Supported
423-DN	8S	Basis Of Cost Determination	Basis Of Cost Not Supported (Add Field 49Ø-UE Compound Ingredient Basis Of Cost Determination to Referenced Fields)

New Reject Codes for Field 511-FB Reject Code			
Field ID	**Reject Code**	**Field Name**	**New Reject Explanation**
426-DQ	8T	Usual And Customary Charge	U&C Must Be Greater Than Zero
43Ø-DU	8U	Gross Amount Due	GAD Must Be Greater Than Zero
431-DV	8V, 8W	Other Payer Amount Paid	Negative Dollar Amount Is Not Supported In The Other Payer Amount Paid Field, Discrepancy Between Other Coverage Code and Other Payer Amount Paid
433-DX	8X, 8Y	Patient Paid Amount Submitted	Collection From Cardholder Not Allowed, Excessive Amount Collected
436-E1	8Z	Product/Service ID Qualifier	Product/Service ID Qualifier Value Not Supported (Add Field 488-RE Compound Product ID Qualifier to Referenced Fields)
439-E4	9B	Reason For Service Code	Reason For Service Code Value Not Supported
44Ø-E5	9C	Professional Service Code	Professional Service Code Value Not Supported
441-E6	9D	Result Of Service Code	Result Of Service Code Value Not Supported
442-E7	9E, 9G, 9H	Quantity Dispensed	Quantity Does Not Match Dispensing Unit, Quantity Dispensed Exceeds Maximum Allowed, Quantity Not Valid For Product/Service ID Submitted
443-E8	9J	Other Payer Date	Future Other Payer Date Not Allowed
447-EC	9K, 9M	Compound Ingredient Component Count	Compound Ingredient Component Count Exceeds Number Of Ingredients Supported, Minimum Of Two Ingredients Required
448-ED	9N	Compound Ingredient Quantity	Compound Ingredient Quantity Exceeds Maximum Allowed
449-EE	9P	Compound Ingredient Drug Cost	Compound Ingredient Drug Cost Must Be Greater Than Zero
452-EH	9Q	Compound Route Of Administration	Compound Route Of Administration Submitted Not Covered
455-EM	9R	Prescription/Service Reference Number Qualifier	Prescription/Service Reference Number Qualifier Submitted Not Covered
457-EP	9S	Associated Prescription/Service Date	Future Associated Prescription/Service Date Not Allowed
461-EU	9T	Prior Authorization Type Code	Prior Authorization Type Code Submitted Not Covered
465-EY	9U	Provider ID Qualifier	Provider ID Qualifier Submitted Not Covered
466-EZ	9V	Prescriber ID Qualifier	Prescriber ID Qualifier Submitted Not Covered
473-7E	9W	DUR/PPS Code Counter	DUR/PPS Code Counter Exceeds Number Of Occurrences Supported
485-KE	9X	Coupon Type	Coupon Type Submitted Not Covered
488-RE	9Y	Compound Product ID Qualifier	Compound Product ID Qualifier Submitted Not Covered
489-TE	9Z	Compound Product ID	Duplicate Product ID In Compound
49Ø-UE	BA	Compound Ingredient Basis Of Cost Determination	Compound Basis of Cost Determination Submitted Not Covered
492-WE	BB	Diagnosis Code Qualifier	Diagnosis Code Qualifier Submitted Not Covered

New Reject Codes for Field 511-FB Reject Code			
Field ID	**Reject Code**	**Field Name**	**New Reject Explanation**
494-ZE	BC	Measurement Date	Future Measurement Date Not Allowed
7Ø2	BD, BF	File Type	Sender Not Authorized To Submit File Type, M/I File Type
88Ø-K1	BG, BH	Sender Id	Sender ID Not Certified For Processor/Payer, M/I Sender ID
88Ø-K6	BJ. BK	Transmission Type	Transmission Type Submitted Not Supported, M/I Transmission Type

Modifications and Deletions to Existing Values:

Existing Code and Message	Fields Referenced	Change/Addition to Referenced Fields
12=M/I Patient Location	3Ø7-Place of Service (Field Name change from Patient Location to Place of Service)	12=M/I Place of Service
54=Non-Matched Product/Service ID Number	4Ø7- Product/Service ID	**Add**: 489-Compound Product ID
55=Non-Matched Product Package Size	4Ø7- Product/Service ID	**Add**: 489-Compound Product ID
77=Discontinued Product/Service ID Number	4Ø7- Product/Service ID	**Add**: 489-Compound Product ID
6Ø=Product/Service Not Covered For Patient Age	3Ø2-Cardholder ID, 3Ø4-Date Of Birth, 4Ø1-Date Of Service, 4Ø7-Product/Service ID	**Add**: 489-Compound Product ID
61=Product/Service Not Covered For Patient Gender	3Ø2-Cardholder ID, 3Ø5-Patient Gender Code, 4Ø7-Product/Service ID	**Add**: 489-Compound Product ID
64=Claim Submitted Does Not Match Prior Authorization	2Ø1-Service Provider ID, 4Ø1-Date Of Service, 4Ø4-Metric Quantity, 4Ø7-Product/Service ID, 416-Prior Authorization/Medical Certification Code And Number	**Add**: 489-Compound Product ID **Change:** Remove 4Ø4 and replace with 442-E7Quantity Dispensed; remove 416 and replace with 461-EU Prior Authorization Type Code and 462-EV Prior Authorization Number Submitted (Note: Fields 4Ø4 and 4Ø7 not supported in Version 5)
78=Cost Exceeds Maximum	4Ø7-Product/Service ID, 4Ø9-Ingredient Cost Submitted, 41Ø-Sales Tax, 442-Quantity Dispensed	**Add**: 489-Compound Product ID; 449-Compound Ingredient Drug Cost; 448-Compound Ingredient Quantity **Change**: Remove 41Ø and replace with 481-HA Flat Sales Tax Amount Submitted and 482-G3 Percentage Sales Tax Amount Submitted (Note: Field 41Ø not supported in Version 5)
75=Prior Authorization Required	462-Prior Authorization Number Submitted	**Add:** 489-Compound Product ID;
AG=Days Supply Limitation For Product/Service	None	**Add:** 489-Compound Product ID and 4Ø7-Product/Service ID
AJ=Generic Drug Required	None	**Add**: 489-Compound Product ID and 4Ø7-Product/Service ID

Existing Code and Message	Fields Referenced	Change/Addition to Referenced Fields
AC=Product Not Covered Non-Participating Manufacturer	None	**Add**: 489-Compound Product ID and 4Ø7-Product/Service ID
R6=Product/Service Not Appropriate For This Location	3Ø7-Patient Location, 4Ø7-Product/Service ID, 436-Product/Service ID Qualifier	**Add**: 489-Compound Product ID
21=Missing/Invalid Product/Service ID	4Ø7-Product/Service ID	**Add:** 489-Compound Product ID
E1=M/I Product/Service ID Qualifier	436-Product/Service ID Qualifier	**Add:** 488-Compound Product ID Qualifier
DN=M/I Basis Of Cost Determination	423- Basis Of Cost Determination	**Add:** 49Ø- Compound Ingredient Basis Of Cost Determination
74=Other Carrier Payment Meets Or Exceeds Payable	4Ø9-Ingredient Cost Submitted, 41Ø-Sales Tax, 442-Quantity Dispensed	**Change:** Remove 41Ø and replace with 481-HA Flat Sales Tax Amount Submitted and 482-G3 Percentage Sales Tax Amount Submitted (Note: Field 41Ø not supported in Version 5)

Existing Code and Message	Fields Referenced	Change
TE=Missing/Invalid Compound Product ID	489-Compound Product ID	**Delete**: This reject code since this field will be referenced in Reject Code "21"=M/I Product/Service ID
RE=M/I Compound Product ID Qualifier	488-Compound Product ID Qualifier	**Delete**: This reject code since this field will be referenced in Reject Code "E1"=M/I Product/Service ID Qualifier
UE= M/I Compound Ingredient Basis Of Cost Determination	49Ø- Compound Ingredient Basis Of Cost Determination	**Delete**: This reject code since this field will be referenced in Reject Code "DN"=M/I Basis Of Cost Determination
38= M/I Basis Of Cost Determination	423-Basis Of Cost Determination	**Delete:** There are two reject codes for M/I for this field, "DN" and "38"

F. PUBLICATION RELEASE JULY 2ØØ5

1. Section II

FIELD	MODIFICATION
492-WE – Diagnosis Code Qualifier	Values Added: Value Ø8 = First DataBank Disease Code (FDBDX), Ø9 = First DataBank FML Disease Identifier (FDB DxID)
6Ø1-19 - Product Code Qualifier	Value Definition Changed: Value 1 = from First DataBank Generic Code Number (GCN) to First DataBank Formulation ID (GCN)
6Ø1-26 - Therapeutic Class Code Qualifier	Value Added: Value 9 = First DataBank Enhanced Therapeutic Class Codes (ETC ID); Value Definition Changed: Value 1 = from First DataBank Generic Code Number (GCN) to First DataBank Formulation ID (GCN)
436-E1 – Product/Service ID Qualifier **Appendix B**	Value Added: Value 28 = First DataBank Medication Name ID (FDB Med Name ID), 29 = First DataBank Routed Medication ID (FDB Routed Med ID), 3Ø = First DataBank Routed Dosage Form ID (FDB Routed Dosage Form Med ID), 31 = First DataBank Medication ID (FDB MedID), 32 = First DataBank Clinical Formulation ID Sequence Number (GCN_SEQ_NO), 33 = First DataBank Ingredient List ID (HICL_SEQ_NO); Value Definition Changed: Value 15 = from First DataBank Generic Code Number (GCN) to First DataBank Formulation ID (GCN)

	Fields Applicable To: Value 15 = added applicability to Product/Service ID Qualifier (436-E1), Compound Product ID Qualifier (488-RE), and Originally Prescribed Product/Service ID Qualifier (453-EJ); Values 28-32 = included applicability to all fields: Product/Service ID Qualifier (436-E1), Compound Product ID Qualifier (488-RE), DUR Co-Agent ID Qualifier (475-J9), Originally Prescribed Product/Service ID Qualifier (453-EJ), and Preferred Product ID Qualifier (552-AP)
367-2N - Prescriber State/ Province Address	New Field Added: Values point to APPENDIX C – UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS (May be used in Telecommunication Standard Version C.Ø or greater but not in lower versions.)
387-3V - Facility State/Province Address	New Field Added: Values point to APPENDIX C – UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS (May be used in Telecommunication Standard Version C.Ø or greater but not in lower versions.)
369-2Q - Additional Documentation Type ID	New Field and Values Added (May be used in Telecommunication Standard Version C.Ø or greater but not in lower versions.)
371-2S - Length of Need Qualifier	New Field and Values Added (May be used in Telecommunication Standard Version C.Ø or greater but not in lower versions.)
373-2U - Request Status	New Field and Values Added (May be used in Telecommunication Standard Version C.Ø or greater but not in lower versions.)
42Ø-DK – Submission Clarification Code	Values Added: Value11=Certification on File – The supplier's guarantee that a copy of the paper certification, signed and dated by the physician, is on file at the supplier's office, Value 12=DME Replacement Indicator – Indicator that this certification is for a DME item replacing a previously purchased DME item.
511-FB Reject Code (APPENDIX A – TELECOMMUNICATION REJECT CODES)	Values added - see following table.

New Codes Added:

New Reject Codes for Field 511-FB Reject Code			
Field ID	**Reject Code**	**Field Name**	**New Reject Explanation**
111-AM	4T	Segment Identification	M/I Additional Documentation
111-AM	AQ	Segment Identification	M/I Facility Segment
111-AM	PQ	Segment Identification	M/I Narrative Segment
364-2J	2J	Prescriber First Name	M/I Prescriber First Name
365-2K	2K	Prescriber Street Address	M/I Prescriber Street Address
366-2M	2M	Prescriber City Address	M/I Prescriber City Address
367-2N	2N	Prescriber State/ Province Address	M/I Prescriber State/Province Address
368-2P	2P	Prescriber Zip/Postal Zone	M/I Prescriber Zip/Postal Zone
369-2Q	2Q	Additional Documentation Type ID	M/I Additional Documentation Type ID
37Ø-2R	2R	Length of Need	M/I Length of Need
371-2S	2S	Length of Need Qualifier	M/I Length of Need Qualifier
372-2T	2T	Prescriber/Supplier Date Signed	M/I Prescriber/Supplier Date Signed
373-2U	2U	Request Status	M/I Request Status
374-2V	2V	Request Period Begin Date	M/I Request Period Begin Date
375-2W	2W	Request Period Recert/Revised Date	M/I Request Period Recert/Revised Date

New Reject Codes for Field 511-FB Reject Code			
Field ID	**Reject Code**	**Field Name**	**New Reject Explanation**
376-2X	2X	Supporting Documentation	M/I Supporting Documentation
377-2Z	2Z	Question Number/Letter Count	M/I Question Number/Letter Count
377-2Z	4N	Question Number/Letter Count	Question Number/Letter Count Does Not Match Number of Repetitions
378-4B	4B	Question Number/Letter	M/I Question Number/Letter
378-4B	4P	Question Number/Letter	Question Number/Letter not Valid for Identified Document
378-4B	4Q	Question Number/Letter	Question Response Not Appropriate for Question Number/Letter
378-4B	4R	Question Number/Letter	Required Question Number/Letter Response for Indicated Document Missing
379-4D	4D	Question Percent Response	M/I Question Percent Response
38Ø-4G	4G	Question Date Response	M/I Question Date Response
381-4H	4H	Question Dollar Amount Response	M/I Question Dollar Amount Response
382-4J	4J	Question Numeric Response	M/I Question Numeric Response
383-4K	4K	Question Alphanumeric Response	M/I Question Alphanumeric Response
385-3Q	3Q	Facility Name	M/I Facility Name
386-3U	3U	Facility Street Address	M/I Facility Street Address
387-3V	3V	Facility State/Province Address	M/I Facility State/Province Address
388-5J	5J	Facility City Address	M/I Facility City Address
389-6D	6D	Facility Zip/Postal Zone	M/I Facility Zip/Postal Zone
39Ø-BM	BM	Narrative Message	M/I Narrative Message

2. Section III

FIELD	MODIFICATION
1153 – Reference Qualifier– Generic Database, Prior Authorization - DRU Segment	Values Added: Values FD = First DataBank Routed Dosage Form ID (FDB Routed Dosage Form Med ID), FI = First DataBank Medication ID (FDB MedID), FL = First DataBank Ingredient List ID (HICL_SEQ_NO), FM = First DataBank Routed Medication ID (FDB Routed Med ID), FN = First DataBank Medication Name ID (FDB Med Name ID); Value Definition Changed: Value FG = from First DataBank Generic Code Number (GCN) Sequence # to First DataBank Clinical Formulation ID Sequence Number (GCN_SEQ_NO)
13Ø-4711 Condition/Response, coded - Patient Consent Indicator	New Field and Values Added (May be used in SCRIPT Standard Version 8.Ø or greater but not in lower versions.)
1131 – Code List Qualifier – Reject Code - STS Segment	Values Added: Values 217 = COO Date/Time/Period Expiration date - of needed history is less than Effective Date (Begin) of needed history, 218 = COO Patient Identifier is invalid, 219 = COO Cannot process Medication History due to value of Condition/Response, coded (Patient Consent Indicator)
1131 – Code List Qualifier – Response Code - RES Segment	Value Added: Value AQ = More Medication History Available.
1131 - Code List Qualifier - Drug Strength Qualifier (X12 DE 355)	Name Changed To: 1131 - Code List Qualifier - used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier, and 6Ø63 - Quantity Qualifier (X12 DE 355); Definition Changed From: *Drug strength qualifier. Unit or Basis for Measurement Code* To *Drug strength qualifier. Unit or Basis for Measurement Code. Also used for measurement unit qualifier. Also used for Quantity Qualifier.*

FIELD	MODIFICATION
6411 - Measurement Unit Qualifier (X12 DE 355)	Definition Changed From: Qualifies the Measurement value. *See 1131 - Code List Qualifier - Drug Strength Qualifier (X12 DE 355).* To *Unit of Measure. See 1131 - Code List Qualifier - used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier, and 6Ø63 - Quantity Qualifier (X12 DE 355).*
6Ø63 - Quantity Qualifier (X12 DE 355)	Definition Changed From*: Unit of Measure. See 1131 - Code List Qualifier - Drug Strength Qualifier (X12 DE 355).* To *Qualifies the Measurement value. See 1131 - Code List Qualifier - used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier, and 6Ø63 - Quantity Qualifier (X12 DE 355).*

G. PUBLICATION RELEASE OCTOBER 2ØØ5

This is the first publication of the ECL for use by the Formulary and Benefit Standard Version 1.Ø

1. Section II

FIELD	MODIFICATION
511-FB - Reject Code (APPENDIX A – REJECT CODES)	Split Appendix into 1 for Telecommunication Reject Codes and 2 for Formulary and Benefit Reject Codes, A2--Added table of reject codes for Formulary and Benefit; A1--Values Added: MG = M/I Other Payer BIN Number; MH = M/I Other Payer Processor Control Number; MJ = M/I Other Payer Group ID; MK = Non-Matched Other Payer BIN Number; MM = Non-Matched Other Payer Processor Control Number; MN = Non-Matched Other Payer Group ID; K5 = M/I Transaction Reference Number; NU = M/I Other Payer Cardholder ID; MP = Non-Matched Other Payer Cardholder ID; MR= Drug Not on Formulary; MS= More than 1 Cardholder Found – Narrow Search Criteria
3Ø7-C7 - Place of Service	Value Definition Changed: Value Ø1 from "Unassigned" to "A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients."; Value 91 from "A duly licensed entity that delivers pharmaceutical goods or services for sale to or use by the final consumer" to "Unassigned".
9Ø8-BW - Copay List Type	New Field and Values Added
912-B3 - Coverage List Type	New Field and Values Added
914-B5 - Drug Qualifier-Step Drug	New Field and Values Added to Appendix B2
916-B7 - Drug Reference Qualifier	New Field and Values Added to Appendix B2
918-B9 - Drug Reference Qualifier -Alternative	New Field and Values Added to Appendix B2
92Ø-CT - Drug Reference Qualifier -Source	New Field and Values Added to Appendix B2
924-DH - First Copay Term	New Field and Values Added
927-FP - Formulary Status	New Field and Values Added
928-FR - List Action	New Field and Values Added
93Ø-F2 - Load Status	New Field and Values Added
931-F8 - Maximum Age Qualifier	New Field and Values Added
934-GC - Maximum Amount Qualifier	New Field and Values Added
935-GF - Maximum Amount Time Period	New Field and Values Added
943-GQ - Minimum Age Qualifier	New Field and Values Added
948-GV - Non-listed Brand Over	New Field and Values Added to new Appendix G

FIELD	MODIFICATION
The Counter Formulary Status	
949-GW - Non-listed Generic Over The Counter Formulary Status	New Field and Values Added to new Appendix G
946-GT - Non-Listed Prescription Brand Formulary Status	New Field and Values Added to new Appendix G
947-GU - Non-listed Prescription Generic Formulary Status	New Field and Values Added to new Appendix G
95Ø-GX - Non-listed Supplies Formulary Status	New Field and Values Added to new Appendix G
955–HR - Pharmacy Type	New Field and Values Added
956-HS - Preference Level	New Field and Values Added
959-HV - Product/Service ID Qualifier - Alternative	New Field and Values Added
961-HX - Product/Service ID Qualifier -Step Drug	New Field and Values Added
963-HZ - Product/Service ID Qualifier -Source	New Field and Values Added
964-JA - Product Type	New Field and Values Added
968-JF - Resource Link Type	New Field and Values Added
974-JN - Step Order	New Field and Values Added
981-JV - Transmission Action	New Field and Values Added
986-KJ - Transmission File Type	New Field and Values Added
436-E1 - Product/Service ID Qualifier	Added “F” to Standard/Version Format
Front Matter of Document	Added “F” to Section I- F - Standards Format Key
APPENDIX B – REFERENCE CODES	Split Appendix into 1 for Product/Service Qualifier and 2 for Drug Reference Values, B1---Added fields 959-HV - Product/Service ID Qualifier – Alternative, 961-HX - Product/Service ID Qualifier -Step Drug, 963-HZ - Product/Service ID Qualifier –Source. B2---Created table and added fields 914-B5 - Drug Qualifier-Step Drug, 916-B7 - Drug Reference Qualifier, 918-B9 - Drug Reference Qualifier –Alternative, 92Ø-CT - Drug Reference Qualifier –Source. Also added SCRIPT field Reference Qualifier– Generic Database, Prior Authorization - DRU Segment (1153)
APPENDIX G-- FORMULARY STATUS CODES	New Appendix—added fields 948-GV - Non-listed Brand Over The Counter Formulary Status, 949-GW - Non-listed Generic Over The Counter Formulary Status, 946-GT - Non-Listed Prescription Brand Formulary Status, 947-GU - Non-listed Prescription Generic Formulary Status, 95Ø-GX - Non-listed Supplies Formulary Status

2. Section III

FIELD	MODIFICATION
Reference Qualifier– Generic Database, Prior Authorization - DRU Segment (1153)	Added field to Section II, APPENDIX B – REFERENCE CODES B2-Drug Reference Values and moved values.

H. PUBLICATION RELEASE JUNE 2ØØ6

1. Section II

FIELD	MODIFICATION
511-FB - Reject Code (APPENDIX A 1– REJECT CODES)	Values Added: A5 = Not Covered Under Part D Law ; A6 = This Medication May Be Covered Under Part B Medication and Therefore Cannot Be Covered Under the Part D Basic Benefit for This Beneficiary ; N1= No patient match found; 2A=M/I Medigap ID; 2B=M/I Medicaid Indicator; 2D=M/I Provider Accept Assignment; 2G=M/I Compound Ingredient Modifier Code Count; 2H=M/I Compound Ingredient Modifier Code; 4S= Compound Product ID Requires a Modifier Code; 4M= Compound Ingredient Modifier Code Count Does Not Match Number of Repetitions
436-E1 – Product/Service ID Qualifier (APPENDIX B 1– REFERENCE CODES)	Values Added: 35 = "Logical Observation Identifier Names and Codes (LOINC) – code set used to report laboratory and clinical observations" to apply to DUR Co-Agent ID Qualifier (475-J9)
6Ø1-76 - Base Price Type	Value Added: ASP = Average Sales Price
573-4V - Basis Of Calculation - Coinsurance	New Field and Values Added (May be used in Telecommunication Standard Version C.2 or greater but not in lower versions.)
423-DN - Basis Of Cost Determination	Field Number Corrected – was in error as 426. Values Added: 1Ø = ASP (Average Sales Price); 11 = AMP (Average Manufacturer Price); 12 = WAC (Wholesale Acquisition Cost) . Value Changed: from *8 = Disproportionate Share Pricing/Public Health Service* to *8 = 34ØB Disproportionate Share Pricing/Public Health Service Pricing* with definition.
522-FM - Basis Of Reimbursement Determination	Values Added: 1Ø = ASP (Average Sales Price); 11 = AMP (Average Manufacturer Price); 12 = 34ØB Disproportionate Share Pricing/Public Health Service Pricing; 13 = WAC (Wholesale Acquisition Cost)
452-EH - Compound Route of Administration	Value Corrected: from *Blank = Not Specified* to *Ø = Not Specified*
36Ø-2B – Medicaid Indicator	New Field and Values Added (May be used in Telecommunication Standard Version C.2 or greater but not in lower versions.)
339-6C - Other Payer ID Qualifier	Value Added: Ø5 = Medicare Carrier Number
361-2D – Provider Accept Assignment Indicator	New Field and Values Added (May be used in Telecommunication Standard Version C.2 or greater but not in lower versions.)
42Ø-DK – Submission Clarification Code	Value Added: 13 = Payer-Recognized Emergency/Disaster Assistance Request

2. Section III

FIELD	MODIFICATION
1153 – Reference Qualifier (X12 DE 128)	Value Added: HPI=National Provider ID; Value Changed: from ZZ=NPI to ZZ=Mutually Defined,
1131 – Code List Qualifier – Reject Code - STS Segment	Value added-new reject code 22Ø=Message is a duplicate

I. PUBLICATION RELEASE SEPTEMBER 2ØØ6

This is the first publication of the ECL for use by the Post Adjudication Standard Version 1.Ø

1. Section II

FIELD	MODIFICATION
391-MT - Patient Assignment Indicator (Direct Member Reimbursement Indicator)	New Field and Values Added (May be used in Telecommunication Standard Version C.3 or greater but not in lower versions.)
393-MV - Benefit Stage Qualifier	New Field and Values Added (May be used in Telecommunication Standard Version C.3 or greater but not in lower versions.)
576-MQ - Amount Attributed To Product Selection Qualifier	New Field and Values Added (May be used in Telecommunication Standard Version C.3 or greater but not in lower versions.)
511-FB - Reject Code (APPENDIX A 1– REJECT CODES)	Values Added: MT=M/I Patient Assignment Indicator (Direct Member Reimbursement Indicator) MU=M/I Benefit Stage Count MX=Benefit Stage Count Does Not Match Number Of Repetitions MV=M/I Benefit Stage Qualifier MW=M/I Benefit Stage Amount
2Ø5 – Adjustment Type	New Field and Values Added
2Ø7 – Administrative Fee Effect Indicator	New Field and Values Added
212 – Benefit Type	New Field and Values Added
218 – Claim Media Type	New Field and Values Added
221 – Client Formulary Flag	New Field and Values Added
223 – Client Pricing Basis Of Cost	New Field and Values Added
226 - COB Primary Claim Type	New Field and Values Added
239 – Communication Type Indicator	New Field and Values Added
245 – Eligibility COB Indicator	New Field and Values Added
247 - Eligibility/Patient Relationship Code	New Field and Values Added
248 – Eligible Coverage Code	New Field and Values Added
25Ø - FDA Drug Efficacy Code	New Field and Values Added
251 – Federal Upper Limit Indicator	New Field and Values Added
252 – Federal DEA Schedule	New Field and Values Added
254 – Fill Number Calculated	New Field and Values Added
257 – Formulary Status	New Field and Values Added
266 - In Network Indicator	New Field and Values Added
272 - MAC Reduced Indicator	New Field and Values Added
273 – Maintenance Drug Indicator	New Field and Values Added
274 – Medicare Plan Code	New Field and Values Added
275 – Medicare Recovery Dispensing Indicator	New Field and Values Added
276 – Medicare Recovery Indicator	New Field and Values Added
279 – Member Submitted Claim Program Code	New Field and Values Added
282 - Non-POS Claim Override Code	New Field and Values Added
288 – Payroll Class	New Field and Values Added
292 – Plan Cutback Reason Code	New Field and Values Added
295 – Prescriber Certification	New Field and Values Added

FIELD	MODIFICATION
Status	
297 – Prescription Over The Counter Indicator	New Field and Values Added
299 – Processor Defined Prior Authorization Reason Code	New Field and Values Added
395 – Processor Payment Clarification Code	New Field and Values Added
398 – Record Indicator	New Field and Values Added
399 – Record Status Code	New Field and Values Added
878 – Reject Override Code	New Field and Values Added
888 – Submission Number	New Field and Values Added
573-4V - Basis of Calculation - Coinsurance	Add "A" for Post Adjudication to the Standards Format Column
347-HJ - Basis Of Calculation - Copay	Moved existing field and values from Data Dictionary
346-HH - Basis Of Calculation - Dispensing Fee	Moved existing field and values from Data Dictionary
348-HK - Basis Of Calculation - Flat Sales Tax	Moved existing field and values from Data Dictionary
349-HM - Basis Of Calculation - Percentage Sales Tax	Moved existing field and values from Data Dictionary
532-FW Database Indicator	Values Added: 6= Redbook, 7= Multum
425-DP Drug Type	Moved existing field and values from Data Dictionary and Value Added: 5 = Multi-source Brand
331-CX Patient ID Qualifier	Values Added: Ø4 = Non-SSN-based patient identifier assigned by health plan Ø5 = SSN-based patient identifier assigned by health plan
981-JV Transmission Action	Values Added: O = Original Submission (New) C = Correction/Adjustment to a previous batch D = Deletion of a previous batch P = Replacement of a previous batch (delete followed by add)
Section 1-F Standards Format Key	Added value of H=Health Care ID Card
Appendix H – Health Care ID Card Values	Appendix added.

J. PUBLICATION RELEASE OCTOBER 2ØØ6

1. Section III

FIELD	MODIFICATION
Section III A 7887- Measurement Data Qualifier	New Field and Values Added (May be used in SCRIPT Standard Version 1Ø.Ø or greater but not in lower versions.)
Section III A *7891- Prior Authorization Status*	New Field and Values Added (May be used in SCRIPT Standard Version 1Ø.Ø or greater but not in lower versions.)
Section III A *7892 - Do Not Fill/Profile Flag*	New Field and Values Added (May be used in SCRIPT Standard Version 1Ø.Ø or greater but not in lower versions.)
Section III A 7893 - Change of Prescription Status Flag	New Field and Values Added (May be used in SCRIPT Standard Version 1Ø.Ø or greater but not in lower versions.)

FIELD	MODIFICATION
Section III B 1153 – Reference Qualifier (X12 DE 128)	Values Added *EA, 1J*, and *EJ*
Section III B 2ØØ5 - Date/Time Period Qualifier (X12 DE 423)	Values Added *35* and *BE*
Section III B 6311 - Measurement Dimension, coded (***Values when referencing*** X12 DE 738)	Bolded added to Name of Field and Note to bottom of Values
Section III C 2379 - Date/Time/Period Format Qualifier	Value Added *2Ø3*

K. PUBLICATION RELEASE JANUARY 2ØØ7

1. Section II

FIELD	MODIFICATION
996-G1 Compound Type	New Field and Values Added (May be used in Telecommunication Standard Version C.4 or greater but not in lower versions.)
997-G2 CMS Part D Defined Qualified Facility	New Field and Values Added (May be used in Telecommunication Standard Version C.4 or greater but not in lower versions.)
995-E2 Route Of Administration	New Field and Values Added (May be used in Telecommunication Standard Version C.4 or greater but not in lower versions.)
338-5C Other Payer Coverage Type	Values Added: Ø4 = Quaternary, Ø5 = Quinary, Ø6 = Senary, Ø7 = Septenary, Ø8 = Octonary, Ø9 = Nonary
429-DT Unit Dose Indicator	Name changed to Special Packaging Indicator; Value Added; 5 = Multi-drug compliance packaging (Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration)
42Ø-DK Submission Clarification Code	Values Added: 13 = Long Term Care Leave of Absence - The pharmacist is indicating that the cardholder requires a short-fill of a prescription due to a leave of absence from the Long Term Care (LTC) facility., 14 = Long Term Care Replacement Medication - Medication has been contaminated during administration in a Long Term Care setting. 15 = Long Term Care Emergency box (kit) or automated dispensing machine – Indicates that the transaction is a replacement supply for doses previously dispensed to the patient after hours. , 16 = Long Term Care Emergency supply remainder - Indicates that the transaction is for the remainder of the drug originally begun from an Emergency Kit., 17 = Long Term Care Patient Admit/Readmit Indicator - Indicates that the transaction is for a new dispensing of medication due to the patient's admission or readmission status.
452-EH Compound Route of Administration	Deleted use by the Telecommunication Standard in order to use new data element Route of Administration
511-FB Reject Code	New Reject Codes Added: A7 = M/I Internal Control Number, E2 = M/I Route of Administration, G1= M/I Compound Type, G2 = M/I CMS Part D Defined Qualified Facility, G4 = Physician Must Contact Plan, G5 = Pharmacist Must Contact Plan, G6 = Pharmacy Not Contracted in Specialty Network, G7 = Pharmacy Not Contracted in Home Infusion Network, G8 = Pharmacy Not Contracted in Long Term Care Network, G9 = Pharmacy Not Contracted in 9Ø Day Retail Network (this message would be used when the pharmacy is not contracted to provide a 9Ø-days supply of drugs)

L. PUBLICATION RELEASE APRIL 2ØØ7

1. Section II

FIELD	MODIFICATION
147-U7 Pharmacy Service Type	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
2Ø2-B2 Service Provider ID Qualifier	Add Rebates To The Standards Format Column (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
436-E1 Product/Service ID Qualifier	**Add Rebates** To The Standards Format Column (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
17Ø-WB Invoice Type 1	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
171-WC Invoice Type 2	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
172-WD Invoice Type 3	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
173-WF Invoice Type 4	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
174-WG Invoice Type 5	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
644-XR Segment Qualifier 1	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
645-XS Segment Qualifier 2	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
646-XT Segment Qualifier 3	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
647-XU Segment Qualifier 4	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
648-XV Segment Qualifier 5	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
649-XW Segment Qualifier 6	New Field and Values Added (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
6Ø1-76 Base Price Type	**Deleted Field**
6Ø1-79 Baseline Qualifier	**Deleted Field**
393-MV Benefit Stage Qualifier	Add Rebates To The Standards Format (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
6ØØ-71 FF Contracting Organization (PMO) ID Qualifier	Name: **Changed** From: FF Contracting Organization (PMO) ID Qualifier To: Contracting Organization (PMO) ID Qualifier Values: **Definitions Added** Format: **Changed** From: x(1) To: x(2)
6Ø1-37 FF Data Provider ID Qualifier	Name: **Changed** From: FF Data Provider ID Qualifier To: Data Provider ID Qualifier Values: **Definitions Added** Format: **Changed** From: x(1) To: x(2)
6ØØ-72 FF Manufacturer (PICO) ID Qualifier	Name: **Changed** From: FF Manufacturer (PICO) ID Qualifier To: Manufacturer (PICO) ID Qualifier Values: **Definitions Added** Format: **Changed** From: x(1) To: x(2)
6Ø1-38 FF Prescriber ID Qualifier	**Deleted Field**
6Ø1-99 Performance Qualifier	**Deleted Field**
6Ø1-46 Pharmacy ID Qualifier	**Deleted Field**
466-EZ Prescriber ID Qualifier	Add Rebates To The Standards Format Column (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)

FIELD	MODIFICATION
	Values: **Added for Rebate:** A=AMA or Medical Education (ME) number B=AOA Doctor of Osteopathy (DO) number C=Contracting Organization PMO number D=DEA number H=HIBCC HIN M=Manufacturer (PICO) assigned number P=National Provider ID T=Telephone number Z=Mutually agreed upon Id number
6Ø1-19 Product Code Qualifier	**Deleted Field**
6Ø2-Ø5 Rebate Type	**Deleted Field**
6Ø2-Ø6 Rebate Type Description	**Deleted Field**
6Ø2-1Ø Reconciliation Reason Code	**Appendix Name Changed:** From: APPENDIX F – CMS RECONCILIATION REASON CODES FOR DETAIL (RD) RECORDS **To: APPENDIX F – CMS RECONCILIATION REASON CODES FOR DETAIL (RS) RECORDS**
6Ø1-31 Data Level	Values **Moved to ECL** and **Added Definitions** Values: **Deleted** CI=Contracting organization pharmacy ID level, CZ=Contracting organization pharmacy zip code level, PI=Plan pharmacy ID level, PZ=Plan pharmacy zip code level
6Ø1-36 FF Action Code (Submit Code)	Values **Moved to ECL** and **Added Definitions** Name: **Changed** From: FF Action Code To: Submit Code Values**: Changed** From: ØØ=Original submission of rebate batch, Ø2= Correction/adjustment to a previously submitted rebate batch, Ø3=Deletion of previously submitted rebate batch, Ø5=Replacement of previously submitted rebate batch To: ØØ=Original or initial submission of data, Ø2=Correction or Adjustment to previous submission rebate period, Ø3= Delete entire previous submission rebate period, Ø5=Replace entire previously submitted rebate period.
6Ø1-48 Plan Reimbursement Qualifier (Reimbursement Qualifier)	Values Moved to ECL Name: **Changed** From: Plan Reimbursement Qualifier To: Reimbursement Qualifier Definition Changed Format: **Changed** From: x(1) To: x(2) **Values: Changed (Added zero due to format change)**
6Ø1-Ø3 Rebate Version Release Number	Values: **Moved to ECL**
6ØØ-58 - Adjudicator ID Qualifier	Values: **Added Definitions**
6ØØ-6Ø Branded Generic Co-pay Confidential	Values: **Moved to ECL**
6ØØ-64 – Change Identifier	Values: **Moved to ECL** and **Added Definitions**
6ØØ-69 - Eligible Plan	Values: **Moved to ECL**
6ØØ-76 Formulary Non-Formulary Co-Pay Confidential	Values: **Moved to ECL**
6Ø1-17 Formulary Product Co-Pay Confidential	Values: **Moved to ECL**
6ØØ-81 - Mail Order ID Qualifier	Values: **Added Definitions**
6Ø1-59 Numerator Indicator	Values: **Moved to ECL**
6ØØ-92 - Plan Affiliation Parent Plan ID Qualifier	Values: **Added Definitions**
6ØØ-95 - Plan ID Qualifier	Values: **Added Definitions**
6Ø1-49 Prescription Type	Values: **Moved to ECL**

FIELD	MODIFICATION
6Ø2-11 Reconciliation Status Code	Values: **Moved to ECL**
6Ø1-53 Record Purpose Indicator	Values: **Moved to ECL**
6Ø1-26 - Therapeutic Class Code Qualifier	Values: **Added Definitions**
4Ø3-D3 Fill Number	Values: **Moved to ECL** Add Rebates To The Standards Format Column (May be used in Manufacturer Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)

M. PUBLICATION RELEASE JULY 2ØØ7

1. Section II

FIELD	MODIFICATION
117-TR Billing Entity Type Indicator	New Field and Values Added (May be used in Telecommunication Standard Version D.Ø or greater but not in lower versions.)
118-TS Pay To Qualifier	New Field and Values Added (May be used in Telecommunication Standard Version D.Ø or greater but not in lower versions.)
123-TX Pay to State/ Province Address	New Field and Values Added (May be used in Telecommunication Standard Version D.Ø or greater but not in lower versions.)
125-TZ Generic Equivalent Product ID Qualifier	New Field and Values Added (May be used in Telecommunication Standard Version D.Ø or greater but not in lower versions.)
131-UG Additional Message Information Continuity	New Field and Values Added (May be used in Telecommunication Standard Version D.Ø or greater but not in lower versions.)
132-UH Additional Message Information Qualifier	New Field and Values Added (May be used in Telecommunication Standard Version D.Ø or greater but not in lower versions.)
139-UR Medicare Part D Coverage Code	New Field and Values Added (May be used in Telecommunication Standard Version D.Ø or greater but not in lower versions.)
143-UW Other Payer-Patient Relationship Code	New Field and Values Added (May be used in Telecommunication Standard Version D.Ø or greater but not in lower versions.)
147-U7 Pharmacy Service Type	Add Telecommunication To The Standards Format (May be used in Telecommunication Standard Version D.Ø or greater but not in lower versions.)
461-EU Prior Authorization Type Code	Values: **Added Definitions** **Changed** 4=Exemption from Copay and/or Coinsurance; **Added**: 9=Emergency Preparedness=Code used to override claim edits during an emergency situation.
479-H8 Other Amount Claimed Submitted Qualifier	Values: **Deleted** Blank=Not Specified
564-J3 Other Amount Paid Qualifier	Values: **Changed** Blank=Not Specified**(This value is not allowed for the Telecommunication Standard)**
576-MQ Amount Attributed to Product Selection Qualifier	**Deleted Field**
548-6F Approved Message Code	Values: **Definitions Added for Values 1-3.** **Added** ØØ4 Filled During Transition Benefit ØØ5 Filled During Transition Benefit/Prior Authorization Required ØØ6 Filled During Transition Benefit/Non-Formulary ØØ7 Filled During Transition Benefit/Other Rejection ØØ8 Emergency Fill Situation ØØ9 Emergency Fill Situation/Prior Authorization Required Ø1Ø Emergency Fill Situation/Non-Formulary Ø11 Emergency Fill Situation/Other rejection Ø12 Level of Care Change

FIELD	MODIFICATION
	Ø13 Level Of Care Change/ Prior Authorization Required Ø14 Level Of Care Change /Non-Formulary Ø15 Level Of Care Change /Other rejection
331-CX Patient ID Qualifier	Values: **Added Definitions** **Deleted** Blank=Not Specified **Added** Ø6=Medicaid ID
468-2E Primary Care Provider ID Qualifier	Values: **Added**15=HCID (HC IDea) = A 1Ø-character, alphanumeric identifier assigned by NCPDP to identify authorized prescribers of drugs. **Deleted** Ø7= NCPDP Provider Identification Number (National Council for Prescription Drug Programs Provider Identification Number) **Changed** 99=Other = used to identify ~~the HCIdea number or~~ other health plans and enumerating organizations not listed above., Blank=Not Specified **(This value is not allowed for the Telecommunication Standard)**
2Ø2-B2 Service Provider ID Qualifier	Values: **Added**15=HCID (HC IDea) = A 1Ø-character, alphanumeric identifier assigned by NCPDP to identify authorized prescribers of drugs. **Changed** 99=Other = used to identify ~~the HCIdea number or~~ other health plans and enumerating organizations not listed above., Blank=Not Specified **(This value is not allowed for the Telecommunication Standard)**
42Ø-DK Submission Clarification Code	Values: **Added** 19**=** Split Billing - indicates the quantity dispensed is the remainder billed to a subsequent payer when Medicare Part A expires. Used only in long-term care settings.; **Changed** Ø=Not Specified, Default **(This value is not allowed for the Telecommunication Standard)**
338-5C Other Payer Coverage Type	Values: **Deleted** 98=Coupon, 99=Composite
339-6C Other Payer ID Qualifier	Values: **Added Definitions** **Deleted** Blank=Not Specified, Ø9=Coupon
342-HC Other Payer Amount Paid Qualifier	Values: **Added Definitions** **Deleted** Blank=Not Specified, Ø8=Sum of All Reimbursements , 98=Coupon, 99=Other
522-FM Basis of Reimbursement Determination	Values: **Definitions Added** **Added** 14**=**Other Payer-Patient Responsibility Amount - Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ)., 15**=**Patient Pay Amount-Indicates reimbursement was based on the Patient Pay Amount (5Ø5-F5). , 16=Coupon Payment–Indicates reimbursement was based on the Coupon Value Amount (487-NE) submitted or coupon amount determined by the processor.
573-4V Basis of Calculation - Coinsurance	Values: **Definitions Added** **Changed** Blank= Not Specified **(This value is not allowed for the Telecommunication Standard)**, ØØ**=** Not Specified **(This value is not allowed for the Telecommunication Standard)**
347-HJ Basis Of Calculation-Copay	Values: **Definitions Added** **Changed** Blank= Not Specified **(This value is not allowed for the Telecommunication Standard)**, ØØ**=** Not Specified **(This value is not allowed for the Telecommunication Standard)**
346-HH Basis Of Calculation-Dispensing Fee	Values: **Definitions Added** **Changed** Blank= Not Specified **(This value is not allowed for the Telecommunication Standard)**, ØØ**=** Not Specified **(This value is not allowed for the Telecommunication Standard)**
423-DN Basis Of Cost Determination	Values: **Definitions Added** **Changed** Blank= Not Specified **(This value is not allowed for the Telecommunication Standard)**, ØØ~~= Not Specified~~ Default Created Appendix I for table of values.
488-RE Compound Product ID Qualifier	Values: **Added Definitions** **Changed** Blank= Not Specified **(This value is not allowed for the Telecommunication Standard)**, **Deleted** Ø5 - Department of Defense (DOD) and 13 - Drug Identification Number (DIN)
485-KE Coupon Type	Values: **Deleted** Blank=Not Specified

FIELD	MODIFICATION
532-FW Database Indicator	Values: **Changed** Blank= Not Specified **(This value is not allowed for the Telecommunication Standard)**
492-WE Diagnosis Code Qualifier	Values: **Changed** Blank= Not Specified **(This value is not allowed for the Telecommunication Standard)**
475-J9 DUR Co-Agent ID Qualifier	Values: **Added Definitions** **Changed** Blank= Not Specified **(This value is not allowed for the Telecommunication Standard)**, **Deleted** Ø5 - Department of Defense (DOD) and 13 - Drug Identification Number (DIN)
549-7F Help Desk Phone Number Qualifier	Values: **Definitions Added** **Deleted** Blank=Not Specified
453-EJ Originally Prescribed Product/Service ID Qualifier	Values:: **Added Definitions** **Deleted** Blank=Not Specified, ØØ=Not Specified; Ø5=Department of Defense (DOD) and 13=Drug Identification Number (DIN)
552-AP Preferred Product ID Qualifier	Values: **Added Definitions** **Deleted** Blank=Not Specified, Ø5=Department of Defense (DOD) and 13=Drug Identification Number (DIN)
419-DJ Prescription Origin Code	Values: **Changed** Ø=Not Known
436-E1 Product/Service ID Qualifier	Values: **Added Definitions** **Changed** Blank= Not Specified **(This value is not allowed for the Telecommunication Standard), Deleted** Ø5=Department of Defense (DOD) and 13=Drug Identification Number (DIN)
465-EY Provider ID Qualifier	Values: **Definitions Added** **Deleted** Blank=Not Specified
511-FB Reject Code	New Reject Codes Added: See table below
466-EZ Prescriber ID Qualifier	Values: (For Telecommunications) **Added**15=HCID (HC IDea) = A 1Ø-character, alphanumeric identifier assigned by NCPDP to identify authorized prescribers of drugs. **Deleted** Ø7= NCPDP Provider Identification Number (National Council for Prescription Drug Programs Provider Identification Number) **Changed** 99=Other = used to identify ~~the HCIdea number or~~ other health plans and enumerating organizations not listed above., Blank=Not Specified **(This value is not allowed for the Telecommunication Standard)**
455-EM Prescription/Service Reference Number Qualifier	Values Moved to ECL Values: (for Telecommunication) **Changed** Blank = Not Specified **(This value is not allowed for the Telecommunication Standard)**
348-HK - Basis Of Calculation -Flat Sales Tax	Values: **Added Definitions**
349-HM - Basis Of Calculation - Percentage Sales Tax	Values: **Added Definitions**
498-PD - Basis Of Request	Values: **Added Definitions**
528-FS – Clinical Significance Code	Values: **Moved to ECL** and **Added Definitions**
4Ø6-D6 - Compound Code	Values: **Moved to ECL**
451-EG – Compound Dispensing Unit Form Indicator	Values: **Moved to ECL** and **Added Definitions**
49Ø-UE - Compound Ingredient Basis of Cost Determination	Values: **Added Values and Definitions from 423-DN Basis Of Cost Determination** Created Appendix I for table of values.
9Ø8-BW - Copay List Type	Values: **Added Definitions**
912-B3 - Coverage List Type	Values: **Added Definitions**
4Ø8-D8 Dispense As Written (DAW)/ Product Selection Code	Values: **Moved to ECL** Ø and 1 Changed Definition; 9 – Changed Name
343-HD – Dispensing Status	Values: **Moved to ECL** and **Added Definitions, Deleted Value of** Blank=Not Specified Add Rebates To The Standards Format Column (May be used in Manufacturer

FIELD	MODIFICATION
	Rebate Standard Version Ø4.Ø1 or greater but not in lower versions.)
914-B5 - Drug Qualifier-Step Drug	Values: **Added Definitions**
474-8E - DUR/PPS Level Of Effort	Values: **Moved to ECL**
7Ø2-MC – File Type	Values: **Moved to ECL** and **Added Definitions**
924-DH - First Copay Term	Values: **Added Definitions**
927-FP - Formulary Status	Values: **Added Definitions**
721-MD Gender Code	Values: **Moved to ECL**
5Ø1-F 1 – Header Response Status	Values: **Moved to ECL** and **Added Definitions**
463-EW – Intermediary Authorization Type ID	Values: **Moved to ECL** and **Added Definitions**
415-DF Number of Refills Authorized	Values: **Moved to ECL**
3Ø8-C8 – Other Coverage Code	Values: **Moved to ECL** and **Added Definitions** **Deleted** Values 5, 6, 7 **Changed Definitions** for Values Ø, 3, 8
351-NP – Other Payer-Patient Responsibility Amount Qualifier	Values: **Moved to ECL** and **Added Definitions** **Added** values Ø9, 1Ø, 11, 12, and 13 **Changed Definitions** to values Ø2 and Ø8 **Field Size Changed:** From x(1) to x(2) (Add a preceding zero to existing values)
529-FT – Other Pharmacy Indicator	Values: **Moved to ECL** and **Added Definitions**
533-FX – Other Prescriber Indicator	Values: **Moved to ECL** and **Added Definitions**
3Ø5-C5 Patient Gender Code	Values: **Moved to ECL**
568-J7 - Payer ID Qualifier	Values: **Added Definitions**
561-AZ – Percentage Sales Tax Basis Paid	Values: **Moved to ECL** and **Added Definitions** **Deleted** value 1
484-JE – Percentage Sales Tax Basis Submitted	Values: **Moved to ECL** and **Added Definitions** **Deleted** value 1
955–HR - Pharmacy Type	Values: **Added Definitions**
335-2C Pregnancy Indicator	Values: **Moved to ECL**
296 Prescriber Taxonomy Code	Values: **Moved to ECL**
44Ø-E5 - Professional Service Code	Values: **Added Definitions**
439-E4 - Reason for Service Code	Values: **Added Definitions**
6Ø1-Ø4 Record Type	Values: **Moved to ECL**
373-2U - Request Status	Values: **Added Definitions**
498-PA - Request Type	Values: **Added Definitions**
441-E6 - Result of Service Code	Values: **Added Definitions**
111-AM Segment Identification	Values: **Moved to ECL** **Added** values 27, 28, and 29
7Ø1 Segment Identifier	Values: **Moved to ECL**
334-1C - Smoker/Non-Smoker Code	Values: **Moved to ECL**
557-AV Tax Exempt Indicator	Values: **Moved to ECL** **Definition Changed** **Values: 1 was defined, 2 was deleted, 3 and 4 were added.**
1Ø3-A3 Transaction Code	Values: **Moved to ECL** **Added** D1=Predetermination of Benefits ; S1=Service Billing; S2=Service Reversal ; S3=Service Rebill
1Ø9-A9 Transaction Count	Values: **Moved to ECL** **Deleted** Blank=Not Specified
112-AN Transaction Response Status	Values: **Moved to ECL** **Added** B=Benefit

FIELD	MODIFICATION
88Ø-K6 Transmission Type	Values: **Moved to ECL**
429-DT –Special Packaging Indicator	Values: **Added Definitions**
6ØØ-28 – Unit of Measure	Values: **Moved to ECL** and **Added Definitions**
1Ø2-A2 Version/Release Number	Values: **Moved to ECL**
959-HV Product/Service ID Qualifier - Alternative	Values: **Added Definitions** **Deleted** Ø5=Department of Defense (DOD) and 13=Drug Identification Number (DIN)
961-HX Product/Service ID Qualifier – Step Drug	Values: **Added Definitions** **Deleted** Ø5=Department of Defense (DOD) and 13=Drug Identification Number (DIN)
963-HZ Product/Service ID Qualifier - Source	Values: **Added Definitions** **Deleted** Ø5=Department of Defense (DOD) and 13=Drug Identification Number (DIN)
916-B7 Drug Reference Qualifier	Values: **Added Definitions**
918-B9 Drug Reference Qualifier-Alternative	Values: **Added Definitions**
92Ø-CT Drug Reference Qualifier-Source	Values: **Added Definitions**
922-CV Drug Reference Qualifier-Step Drug	Values: **Added Definitions**

Modification	Reject Code (511-FB)	Reject Message	Field Possibly In Error
Added	TR	M/I Billing Entity Type Indicator	117
Added	TS	M/I Pay To Qualifier	118
Added	VA	Pay To Qualifier Submitted Not Supported	118
Added	TT	M/I Pay To ID	119
Added	TU	M/I Pay To Name	12Ø
Added	TV	M/I Pay To Street Address	121
Added	TW	M/I Pay To City Address	122
Added	TX	M/I Pay to State/ Province Address	123
Added	TY	M/I Pay To Zip/Postal Zone	124
Added	TZ	M/I Generic Equivalent Product ID Qualifier	125
Added	VB	Generic Equivalent Product ID Qualifier Submitted Not Supported	125
Added	UA	M/I Generic Equivalent Product ID	126
Added	U7	M/I Pharmacy Service Type	147
Added	VC	Pharmacy Service Type Submitted Not Supported	
Added	N7	Use Prior Authorization Code Provided During Transition Period	
Added	N8	Use Prior Authorization Code Provided For Emergency Fill	
Added	N9	Use Prior Authorization Code Provided For Level of Care Change	
Added	RL	Transitional Benefit/Resubmit Claim	
Added	TN	Emergency Fill/Resubmit Claim	
Added	TP	Level of Care Change/Resubmit Claim	
Added	TQ	Dosage Exceeds Product Labeling Limit	442, 4Ø5
Added	UU	DAW Ø cannot be submitted on a multi-source drug with available generics.	
Added	VD	Eligibility Search Time Frame Exceeded	
Added	UZ	Other Payer Coverage Type (338-5C) required on reversals to downstream payers. Resubmit reversal with this field.	338
Added	ZA	The Coordination of Benefits/Other Payments Segment is mandatory to a downstream payer.	
Added	N3	M/I Medicaid Paid Amount	113
Added	N4	M/I Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)	114
Added	N5	M/I Medicaid ID Number	115
Added	N6	M/I Medicaid Agency Number	116

Modification	Reject Code (511-FB)	Reject Message	Field Possibly In Error
Changed	A6	From: This Medication May Be Covered Under Part B And Therefore Cannot Be Covered Under The Part D Basic Benefit For This Beneficiary. To: This Medication May Be Covered Under Part B.	

2. Section III

a) A - NCPDP-Created Data Elements

FIELD	MODIFICATION
4343 Message Function, coded	Values: **Added** A=Admit, C=Change, C1=Significant Change (Any changes to the drug, form, strength, dosage, or route), C2=Frequency Change (Any change to the frequency or hours of administration for the drug), C3=Insignificant Change (All other changes), D1=Discharge – Expired, D2=Discharge – Return Not Anticipated, D3=Discharge – Return Anticipated, D4=Discharge Other

b) B - ASC X12 Data Elements

FIELD	MODIFICATION
47Ø3 Insurance Type, coded (X12 DE 1138)	New Field and Values Added (May be used in SCRIPT Standard Version 1Ø.1 or greater but not in lower versions.)
1153 – Reference Qualifier (X12 DE 128)	Values: **Added** C1=Commercial, IP=Individual Policy Number
1131 – Code List Qualifier – Communication Number - PVD, PTT Segment (X12 DE 365)	Field Heading: **Changed** to Code List Qualifier –Communication Number - PVD, PTT, COO Segment (X12 DE 365)
1131 – Code List Qualifier – used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier, and 6Ø63 - Quantity Qualifier (X12 DE 355)	Split into 2 new fields ***1131 – Code List Qualifier – used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier*** and ***1131 – Code List Qualifier – used for 6Ø63 - Quantity Qualifier (X12 DE 355)***
1131 – Code List Qualifier – Reject Code - STS Segment	Values: **Added** 221-226
2ØØ5 – Date/Time/Period Qualifier	Value **Added** of 74

c) C - UN/EDIFACT Data Elements

FIELD	MODIFICATION
2Ø29 Time Zone Identifier	New Field and Value Added (May be used in SCRIPT Standard Version 1Ø.2 or greater but not in lower versions.)

N. PUBLICATION RELEASE JANUARY 2ØØ8

THIS IS THE FIRST PUBLICATION OF THE ECL FOR USE BY THE FINANCIAL INFORMATION REPORTING STANDARD VERSION 1.Ø AND PRESCRIPTION TRANSFER STANDARD VERSION 1.Ø

1. Section II

FIELD	MODIFICATION
6Ø4-NA Address Qualifier	New Field and Values Added for Prescription Transfer
6Ø6-NC Discontinue Date Qualifier	New Field and Values Added for Prescription Transfer
6Ø8-NF Easy Open Cap Indicator	New Field and Values Added for Prescription Transfer
611-NJ File Structure Type	New Field and Values Added for Prescription Transfer
612-NK Inactive Prescription Indicator	New Field and Values Added for Prescription Transfer
621-RY Prescriber Specialty	New Field and Values Added for Prescription Transfer Created Appendix J in Section II for the values for this field and SCRIPT field 47Ø7 Provider Specialty, coded (X12 DE 1222)
629-SH Telephone Number	New Field and Values Added for Prescription Transfer Created Appendix K in Section II for the values for this field and SCRIPT field 1131 – Code List Qualifier – Communication Number - PVD, PTT, COO Segment (X12 DE 365)
631-SK Transfer Flag	New Field and Values Added for Prescription Transfer
632-SM Transfer Type	New Field and Values Added for Prescription Transfer
635-SQ Unique Record Identifier Qualifier	New Field and Values Added for Prescription Transfer
339-6C Other Payer ID Qualifier	Add Prescription Transfer To The Standards Format Column Values added for Prescription Transfer only.
331-CX Patient ID Qualifier	Add Prescription Transfer To The Standards Format Column Values added
3Ø6-C6 Patient Relationship Code	Add Prescription Transfer To The Standards Format Column Values added
6Ø1-Ø4 Record Type	Add Prescription Transfer To The Standards Format Column Values added for Prescription Transfer only.
1Ø2-A2 Version/Release Number	Add Prescription Transfer To The Standards Format Column Value added Add Post Adjudication Value of 2Ø Add Financial Information Reporting To The Standards Format Column Value added
4Ø6-D6 Compound Code	Add Prescription Transfer To The Standards Format Column
4Ø8-D8 Dispense As Written (DAW)/ Product Selection Code	Add Prescription Transfer To The Standards Format Column
7Ø2-MC File Type	Add Prescription Transfer To The Standards Format Column
4Ø3-D3 Fill Number	Add Prescription Transfer To The Standards Format Column
415-DF Number of Refills Authorized	Add Prescription Transfer To The Standards Format Column
453-EJ Originally Prescribed Product/Service ID Qualifier	Add Prescription Transfer To The Standards Format Column
3Ø5-C5 Patient Gender Code	Add Prescription Transfer To The Standards Format Column
384-4X Patient Residence	Add Prescription Transfer To The Standards Format Column
568-J7 Payer ID Qualifier	Add Prescription Transfer To The Standards Format Column
335-2C Pregnancy Indicator	Add Prescription Transfer To The Standards Format Column
466-EZ Prescriber ID Qualifier	Add Prescription Transfer To The Standards Format Column
436-E1 Product/Service ID Qualifier	Add Prescription Transfer To The Standards Format Column
2Ø2-B2 Service/Provider ID Qualifier	Add Prescription Transfer To The Standards Format Column
334-1C Smoker/Non-Smoker Code	Add Prescription Transfer To The Standards Format Column
511-FB Reject Code	Add Prescription Transfer To The Standards Format Column Values added—see table below for reject codes added Add Financial Information Reporting To The Standards Format Column Values added—see table below for reject codes added

FIELD	MODIFICATION
	Added values: X8, X9, YA-YH, and YJ.
Appendix A – Reject Codes	Modified name to Reject Code for 511-FB Note added to refer to the Standard/Version Column of 511-FB for Standards Use. Modified name of A1 from Telecommunication Reject Codes to Reject Codes
15Ø Pharmacy Class Code Qualifier	New Field and Values Added for Post Adjudication
146 Pharmacy Dispenser Type Qualifier	New Field and Values Added for Post Adjudication
393-MV Benefit Stage Qualifier	Add Post Adjudication To The Standards Format Column Value added
997-G2 CMS Part D Defined Qualified Facility	Add Post Adjudication To The Standards Format Column
452-EH Compound Route of Administration	Deleted Field
996-G1 Compound Type	Add Post Adjudication To The Standards Format Column Value added
384-4X Patient Residence	Add Post Adjudication To The Standards Format Column
3Ø7-C7 Place of Service	Add Post Adjudication To The Standards Format Column Value added
6Ø1-19 Product Code Qualifier	Add Post Adjudication To The Standards Format Column Value added
399 Record Status Code	Value deleted
6Ø1-Ø4 Record Type	Value description modified and value added
995-E2 Route Of Administration	Add Post Adjudication To The Standards Format Column
6Ø1-26 Therapeutic Class Code Qualifier	Add Post Adjudication To The Standards Format Column Value added
655 S6 Accumulator Month	New Field and Values Added for Financial Information Reporting
5Ø1-F1 Header Response Status	Add Financial Information Reporting To The Standards Format Column
111-AM Segment Identification	Add Financial Information Reporting To The Standards Format Column Values added
1Ø3-A3 Transaction Code	Add Financial Information Reporting To The Standards Format Column Values added
1Ø9-A9 Transaction Count	Add Financial Information Reporting To The Standards Format Column
112-AN Transaction Response Status	Add Financial Information Reporting To The Standards Format Column Values added for FIR Use
Appendix E - Reconciliation Reason Codes For Detail And Rebate Records	New table for values applicable for Manufacturer Rebates Standard Version Ø4.Ø1 Added note to existing table of values as applicable to Manufacturer Rebates Standard Version Ø3.Ø2 only
Appendix F – CMS Reconciliation Reason Codes For Detail (RS) Records	Renamed to CMS Reconciliation Reason Codes For State Detail (RS) Records
914-B5 - Drug Qualifier-Step Drug	Corrected value of M to SM
4Ø8-D8 Dispense As Written (DAW)/ Product Selection Code	Definition of Value “1” modified—to add “*Medically Necessary*” to verbiage.

Codes Added to 511-FB Reject Code for Prescription Transfer

Reject Code	Reject Message	Field Possibly In Error
MY	M/I Address Count	6Ø3-MY
TG	Address Count Does Not Match Number Of Repetitions	6Ø3-MY
NA	M/I Address Qualifier	6Ø4-NA
NB	M/I Client Name	6Ø5-NB
NC	M/I Discontinue Date Qualifier	6Ø6-NC
ND	M/I Discontinue Date	6Ø7-ND
NF	M/I Easy Open Cap Indicator	6Ø8-NF
NG	M/I Effective Date	6Ø9-NG
NH	M/I Expiration Date	61Ø-NH
NJ	M/I File Structure Type	611-NJ
NK	M/I Inactive Prescription Indicator	612-NK
NM	M/I Label Directions	613-NM

Reject Code	Reject Message	Field Possibly In Error
NW	M/I Most Recent Date Filled	614-NW
NY	M/I Number Of Fills To-Date	615-NY
PU	M/I Number Of Fills Remaining	616-PU
RQ	M/I Original Dispensed Date	617-RQ
RR	M/I Patient ID Qualifier Count	618-RR
TH	Patient ID Qualifier Count Does Not Match Number Of Repetitions	618-RR
RW	M/I Prescribed Drug Description	619-RW
RX	M/I Prescriber ID Count	62Ø-RX
TJ	Prescriber ID Count Does Not Match Number Of Repetitions	62Ø-RX
RY	M/I Prescriber Specialty	621-RY
RZ	M/I Prescriber Specialty Count	622-RZ
TK	Prescriber Specialty Count Does Not Match Number Of Repetitions	622-RZ
SA	M/I Quantity Dispensed To Date	623-SA
SB	M/I Record Delimiter	624-SB
SC	M/I Remaining Quantity	625-SC
SD	M/I Sender Name	626-SD
UØ	M/I Sending Pharmacy ID	627-SF
VØ	M/I Telephone Number Count	628-SG
TM	Telephone Number Count Does Not Match Number Of Repetitions	628-SG
WØ	M/I Telephone Number Qualifier	629-SH
SJ	M/I Total Number Of Sending And Receiving Pharmacy Records	63Ø-SJ
SK	M/I Transfer Flag	631-SK
SM	M/I Transfer Type	632-SM
SN	M/I Package Acquisition Cost	633-SN
SP	M/I Unique Record Identifier	634-SP
SQ	M/I Unique Record Identifier Qualifier	635-SQ
TD	M/I Pharmacist Initials	636-TD
TF	M/I Technician Initials	637-TF
W5	M/I Bed	671-W1
W6	M/I Facility Unit	672-W2
W7	M/I Hours of Administration	673-W3
W8	M/I Room	674-W4

Codes Added to 511-FB Reject Code for Financial Information Reporting

Reject Code	Reject Message	Field Possibly In Error
S1	M/I Accumulator Year	65Ø
S2	M/I Transaction Identifier	651
S3	M/I Accumulated Patient True Out Of Pocket Amount	652
S4	M/I Accumulated Gross Covered Drug Cost Amount	653
S8	Non-Matched Transaction Identifier	651
S9	M/I Financial Information Reporting Transaction Header Segment	111
X5	M/I Financial Information Reporting Request Insurance Segment	111
X6	M/I Request Financial Segment	111
X7	Financial Information Reporting Request Insurance Segment Required For Financial Reporting	111
T1	Request Financial Segment Required For Financial Information Reporting	111
T2	M/I Request Reference Segment	111
S5	M/I DateTime	654
S6	M/I Accumulator Month	655
S7	M/I Accumulator Month Count	656
SØ	Accumulator Month Count Does Not Match Number of Repetitions	656
TØ	Accumulator Month Count Exceeds Number of Occurrences Supported	656
T3	Out of Order DateTime	654
T4	Duplicate DateTime	654
SW	Accumulated Patient True Out of Pocket must be equal to or greater than zero	652
W9	Accumulated Gross Covered Drug Cost Amount must be equal to or greater than zero	653
X1	Accumulated Patient True Out of Pocket exceeds maximum	652
X2	Accumulated Gross Covered Drug Cost exceeds maximum	653

Reject Code	Reject Message	Field Possibly In Error
X3	Out of order Accumulator Months	656, 655
X4	Accumulator Year not current or prior year	65Ø

2. Section III

a) A - NCPDP-Created Data Elements

FIELD	MODIFICATION
1131 – Code List Qualifier – Reject Code - STS Segment	Values: **Added** 227=Message missing required SRC Segment 228=SRC Source Qualifier is invalid 229=SRC Source Description is invalid 23Ø=SRC Source Reference Number is invalid 231=SRC Source Reference Qualifier is invalid 232=SRC Reference Number is invalid 233=SRC Fill Number is invalid 234=Too many SRC Segments 235=Too many SRC element repetitions 236=Too many elements in SRC Segment

b) B - ASC X12 Data Elements

FIELD	MODIFICATION
1131 – Code List Qualifier – Quantity Qualifier - DRU Segment (X12 DE 673)	Value **Added** of QS

c) C – UN/EDIFACT Data Elements

FIELD	MODIFICATION
7895 – Source Qualifier	New Field and values added for SCRIPT Standard Version 1Ø.3

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1. Section II

FIELD	MODIFICATION
2Ø5 - Adjustment Type	Values - Added definitions
2Ø7 - Administrative Fee Effect Indicator	Values – Deleted defintions
548-6F - Approved Message Code	Values – Added new ØØ4 – Ø15
393-MV - Benefit Stage Qualifier	Values - Added definitions
212 - Benefit Type	Values - Added definitions
218 – Claim Media Type	Values - Added definitions
223 – Client Pricing Basis Of Cost	Values – Modified definitions
226 – COB Primary Claim Type	Values - Added definitions
239 – Communication Type Indicator	Values – Modified definitions
4Ø6-D6 - Compound Code	Values – Modified definitions
45Ø-EF - Compound Dosage Form Description Code	Values – Modified definitions
996-G1 - Compound Type	Values - Added definitions
485-KE - Coupon Type	Values - Added definitions
532-FW - Database Indicator	Values - Added definitions
6Ø1-31 – Data Level	Values – Removed values RS and US that were added in error
357-NV - Delay Reason Code	Values - Added definitions

FIELD	MODIFICATION
492-WE – Diagnosis Code Qualifier	Values - Added definitions
4Ø8-D8 Dispense As Written (DAW)/ Product Selection Code	Values - Modified value of “1”
425-DP – Drug Type	Values - Added definitions
3Ø9-C9 – Eligibility Clarification Code	Values - Added definitions
245 – Eligibility COB Indicator	Values - Added definitions
248 – Eligible Coverage Code	Values - Added definition for value of “TWO”
4Ø3-D3 Fill Number	Values - Added definitions
254 – Fill Number Calculated	Values - Added definitions
257 - Formulary Status	Values - Added definitions
266 – In Network Indicator	Values - Added definitions
371-2S - Length of Need Qualifier	Values - Added definitions
418-DI – Level of Service	Values - Added definitions
928-FR - List Action	Values - Added definitions
93Ø-F2 - Load Status	Values - Added definitions
272 – MAC Reduced Indicator	Values - Modified definition for value of “N”
273 – Maintenance Drug Indicator	Values - Added definitions
931-F8 - Maximum Age Qualifier	Values - Added definitions
934-GC - Maximum Amount Qualifier	Values - Added definitions
935-GF - Maximum Amount Time Period	Values - Added definitions
496-H2 - Measurement Dimension	Values - Added definitions
497-H3 - Measurement Unit	Values - Added definitions
139-UR – Medicare Part D Coverage Code	Values - Added definitions
274 – Medicare Plan Code	Values - Added definitions
275 – Medicare Recovery Dispensing Indicator	Values - Modified definitions
276 – Medicare Recovery Indicator	Values - Added definitions
6ØØ-83 - Membership Count Qualifier	Values - Added definitions
6ØØ-86 - Membership Period Qualifier	Values - Added definitions
6ØØ-89 - Membership Type Qualifier	Values - Added definitions
279 – Member Submitted Claim Program Code	Values - Added definitions
943-GQ - Minimum Age Qualifier	Values - Added definitions
479-H8 - Other Amount Claimed Submitted Qualifier	Values - Added definitions
564-J3 - Other Amount Paid Qualifier	Values - Added definitions
338-5C - Other Payer Coverage Type	Values - Added definitions
143-UW – Other Payer Patient Relationship Code	Values - Added definitions
391-MT - Patient Assignment Indicator (Direct Member Reimbursement Indicator)	Values - Added definitions
331-CX - Patient ID Qualifier	Values - Added definitions
3Ø6-C6 - Patient Relationship Code	Values - Added definitions
3Ø7-C7 – Place of Service	Values - Added new value of “16”
292 - Plan Cutback Reason Code	Values - Added definitions
295 – Prescriber Certification Status	Values - Added definitions
466-EZ - Prescriber ID Qualifier	Values - Added definitions for Rebate values
419-DJ – Prescription Origin Code	Values - Added definitions
297 – Prescription Over The Counter Indicator	Values - Added definitions
455-EM Prescription/Service Reference Number	Values - Added definitions

FIELD	MODIFICATION
Qualifier	
6Ø1-49 Prescription Type	Values - Added definitions
663-V2 - Prior Authorization Applicability	New Field and Values Added for Formulary and Benefit
668-V7 - Prior Authorization Comparison Type	New Field and Values Added for Formulary and Benefit
66Ø-T8 - Prior Authorization Question Code Qualifier	New Field and Values Added for Formulary and Benefit
664-V3 - Prior Authorization Required Question	New Field and Values Added for Formulary and Benefit
665-V4 - Prior Authorization Response Type	New Field and Values Added for Formulary and Benefit
436-E1 – Product/Service ID Qualifier	Value of “36” added
959-HV - Product/Service ID Qualifier - Alternative	Value of “36” added
961-HX - Product/Service ID Qualifier -Step Drug	Value of “36” added
963-HZ - Product/Service ID Qualifier -Source	Value of “36” added
964-JA - Product Type	Values - Added definitions
361-2D – Provider Accept Assignment Indicator	Values - Added definitions
6Ø2-11 Reconciliation Status Code	Values - Added definitions
399 – Record Status Code	Values - Added definitions
6Ø1-Ø4- Record Type	Values - Added new values for Formulary and Benefit
968-JF - Resource Link Type	Values - Added definitions
644-XR Segment Qualifier 1	Values - Added definitions
334-1C - Smoker/Non-Smoker Code	Values - Added definitions
112-AN Transaction Response Status	Values - Added definitions
981-JV - Transmission Action	Values - Added definitions
88Ø-K6 Transmission Type	Values - Added definitions

2. Section III

b) A - NCPDP-Created Data Elements

FIELD	MODIFICATION
7943 – Administration Timing Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7919 –Body Metric Qualifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7923 – Calculated Dose Unit of Measure Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7893 - Change of Prescription Status Flag	Values - Added definitions
681Ø - Clinical Information Qualifier	Values - Added definitions
1131 – Code List Qualifier – Diagnosis Code Qualifier (Primary) - DRU Segment	Values - Added definitions
1131 – Code List Qualifier – Reject Code - STS Segment	Values - Added new values 237-343; Changed definition for Code 58
7996 - DEA Schedule	New Field and Values Added for SCRIPT Standard Version 1Ø.5
7925 –Dose Basis Range Modifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
79Ø3 –Dose Composite Indicator - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
79Ø5 –Dose Delivery Method Code	New Field and Values Added for SCRIPT Standard Version 1Ø.4

FIELD	MODIFICATION
Qualifier - SIG Segment	
79Ø8 –Dose Delivery Method Modifier Code Qualifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
3229 - Country Sub-entity Identification	New Field and Values Added for SCRIPT Standard Version 1Ø.5
7912 –Dose Form Code Qualifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7914 –Dose Range Modifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7917 – Dosing Basis Unit of Measure Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7882 - DUE Co-Agent ID Qualifier	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7965 – Duration Text Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7885- Drug Coverage Status Code	Values - Added definitions
7955 – Frequency Units Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7977 – Indication Precursor Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
798Ø – Indication Text Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7985 – Indication Value Unit of Measure Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7987 –Indication Variable Modifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
97Ø1 - Individual Relationship, coded	Values - Added definitions
796Ø – Interval Units Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7992 - Item Form Code	New Field and Values Added for SCRIPT Standard Version 1Ø.5
7993 - Item Strength Code	New Field and Values Added for SCRIPT Standard Version 1Ø.5
7969 – Maximum Dose Restriction Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7975 – Maximum Dose Restriction Variable Duration Modifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7973 – Maximum Dose Restriction Variable Units Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7995 Measurement Unit Code	New Field and Values Added for SCRIPT Standard Version 1Ø.5
4343 – Message Function, coded	Values - Added definitions and added new values
7945 –Multiple Administration Timing Modifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7937 –Multiple Route of Administration Modifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7899 – Multiple Sig Modifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4

FIELD	MODIFICATION
7941 –Multiple Site of Administration Timing Modifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7933 –Multiple Vehicle Modifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7994 Potency Unit Code	New Field and Values Added for SCRIPT Standard Version 1Ø.5
7891- Prior Authorization Status	Values - Added definitions
799Ø - Provider Specialty code (replacing 47Ø7 - Provider Specialty, coded (X12 DE 1222))	New Field and Values Added for SCRIPT Standard Version 1Ø.5
7948 – Rate Unit of Measure Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7935 – Route of Administration Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
79Ø2 –Sig Free Text String Indicator - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7939 – Site of Administration Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7991 - Source Code List	New Field and Values Added for SCRIPT Standard Version 1Ø.5
7988 –Stop Indicator - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7951 – Time Period Basis Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7957 –Variable Frequency Modifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7962 –Variable Interval Modifier - SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7927 – Vehicle Name Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4
7931 – Vehicle Unit of Measure Code Qualifier – SIG Segment	New Field and Values Added for SCRIPT Standard Version 1Ø.4

b) B - ASC X12 Data Elements

FIELD	MODIFICATION
47Ø9 - Agency Qualifier, coded	Deleted existing values (may be used in SCRIPT Standard Versions 5.Ø - 1Ø.4; added new value for use in SCRIPT Standard Version 1Ø.5 or higher
1131 – Code List Qualifier – Drug Form - DRU Segment (X12 DE 133Ø)	Deleted Field—May be used in SCRIPT Standard Versions 5.Ø – 1Ø.4 but not in SCRIPT Standard Version 1Ø.5 or greater
1131 – Code List Qualifier – used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier	Deleted Field—May be used in SCRIPT Standard Versions 5.Ø – 1Ø.4 but not in SCRIPT Standard Version 1Ø.5 or greater
1131 – Code List Qualifier – used for 6Ø63 - Quantity Qualifier (X12 DE 355)	Deleted Field—May be used in SCRIPT Standard Versions 5.Ø – 1Ø.4 but not in SCRIPT Standard Version 1Ø.5 or greater
2ØØ5 - Date/Time/Period Qualifier (X12 DE 432)	Value of “Ø6”
47Ø7 - Provider Specialty	Deleted Field—May be used in SCRIPT Standard Versions 5.Ø – 1Ø.4 but not in SCRIPT Standard Version 1Ø.5 or greater
1153 – Reference Qualifier (X12 DE 128)	Value of “ADI” added

c) C – UN/EDIFACT Data Elements

FIELD	MODIFICATION

FIELD	MODIFICATION
77Ø1 Service Type, coded	New Field and Values Added for SCRIPT Standard Version 1Ø.4