Prescryptive Health D.0 Payer Sheet
Prescryptive Pricing

GENERAL INFORMATION

Payer Name: Prescryptive Health	Date: 3/11/2024	
Plan Name: Prescryptive Pricing	BIN: 026944	PCN: X01
Processor: Prescryptive Health	GROUP: 200P32F	
Effective as of: 7/1/2022	NCPDP Telecommunication Standard Version/Release #: D.0	
	NCPDP External Code List Version Date: 1/1/2019	
Contact/Information Source : pharmacyrelations@prescryptive.com		
Pharmacy Help Desk: 512-851-1853		

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
SITUATIONAL	**S**	The field is Situational and required only when other insurance processing is involved	Yes
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

CLAIM BILLING/CLAIM REBILL TRANSACTION

The following lists the segments and fields in a Claim Billing or Claim Rebill Transaction for the

NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Reversal Window	30 Days

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

	Transaction Header Segment			Claim Billing/Claim Rebill	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	
1Ø1-A1	BIN NUMBER	BIN: 026944	M		
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M		
1Ø3-A3	TRANSACTION CODE	B1, B2, or E1	M	B1= Claim B2= Reversal	
1Ø4-A4	PROCESSOR CONTROL NUMBER	X01	M		
1Ø9-A9	TRANSACTION COUNT	1	M		
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M		
2Ø1-B1	SERVICE PROVIDER ID		M		
4Ø1-D1	DATE OF SERVICE		M	YYYMMDD	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		M		

Prescryptive Health D.0 Payer Sheet
Prescryptive Pricing

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

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	*If no member ID, 10-digit phone number*
312-CC	CARDHOLDER FIRST NAME		R	
313-CD	CARDHOLDER LAST NAME		R	
314-CE	HOME PLAN		O	
524-FO	PLAN ID		O	
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE		O	
3Ø1-C1	GROUP ID		R	
3Ø3-C3	PERSON CODE	00-01,02,03,04,05	R	00= Self 01=Spouse 02+- Dependents
3Ø6-C6	PATIENT RELATIONSHIP CODE	1	R	

Patient Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent				
This Segment is situational				

	Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing/Claim Rebill
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
331-CX	PATIENT ID QUALIFIER		O	
332-CY	PATIENT ID		O	
3Ø4-C4	DATE OF BIRTH		R	YYYYMMDD
3Ø5-C5	PATIENT GENDER CODE	1 OR 2	R	1-MALE 2- FEMALE
31Ø-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		R	
323-CN	PATIENT CITY ADDRESS		R	
324-CO	PATIENT STATE / PROVINCE ADDRESS		R	
325-CP	PATIENT ZIP/POSTAL ZONE		R	*ZIP CODE MUST BE A VALID 5 OR 9 DIGIT USPS ZIP CODE AND MUST NOT INCLUDE HYPHENS OR ALL ZERIOS IN POSITIONS 6 THROUH 9*
326-CQ	PATIENT PHONE NUMBER		M	*must be 10 digit numeric*
3Ø7-C7	PLACE OF SERVICE		O	
333-CZ	EMPLOYER ID		O	
335-2C	PREGNANCY INDICATOR		R	
35Ø-HN	PATIENT E-MAIL ADDRESS		O	
384-4X	PATIENT RESIDENCE		R	Home=1 Long term Care=3,4,6,9, or 11

Prescryptive Health D.Ø Payer Sheet
Prescryptive Pricing

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

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER		R	*Imp Guide:* Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription.
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE		R	*Imp Guide:* Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if Associated Prescription/Service Reference Number (456-EN) is used. Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription.
458-SE	PROCEDURE MODIFIER CODE COUNT	1- 1Ø.	O	*If present, must = total # of group occurrences*
459-ER	PROCEDURE MODIFIER CODE			*Imp Guide:* Required to define a further level of specificity if the Product/Service ID (4Ø7-D7) indicated a Procedure Code was submitted. Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* (any unique payer requirement(s))
442-E7	QUANTITY DISPENSED		R	Must be present and > Ø
4Ø3-D3	FILL NUMBER	Ø, 1-99	R	The values defined for this field are Ø= Original fill, and 1-99 refill
4Ø5-D5	DAYS SUPPLY		R	Must be present and > Ø
4Ø6-D6	COMPOUND CODE	1 or 2	R	1= Not a compound 2=Compound, if 2 is submitted, then compound segment is required
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Ø-9	R	
414-DE	DATE PRESCRIPTION WRITTEN		R	YYYMMDD
415-DF	NUMBER OF REFILLS AUTHORIZED		O	*If present, value must be Ø, 1-99*
419-DJ	PRESCRIPTION ORIGIN CODE	1, 2, 3, 4 or 5	M	*1= Written 2=Telephonic, 3=Electronic, 4=Facsimile, 5=Pharmacy*
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.		
42Ø-DK	SUBMISSION CLARIFICATION CODE		O	
46Ø-ET	QUANTITY PRESCRIBED		R	
3Ø8-C8	OTHER COVERAGE CODE	ØØ,Ø1	R	

429-DT	SPECIAL PACKAGING INDICATOR		O	
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER		O	
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE		O	
446-EB	ORIGINALLY PRESCRIBED QUANTITY		O	
454-EK	SCHEDULED PRESCRIPTION ID NUMBER		O	Required if necessary for state/federal/regulatory agency programs.
6ØØ-28	UNIT OF MEASURE		O	*If present, must be EA, GM, ML, etc.*
418-DI	LEVEL OF SERVICE		O	*If present, must be Ø,1-6*
461-EU	PRIOR AUTHORIZATION TYPE CODE		R	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:*
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		O	*May be required if Submitting Prior Authorization*
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID		O	*May be required if Submitting Prior Authorization*
464-EX	INTERMEDIARY AUTHORIZATION ID		O	*May be required if Submitting Prior Authorization*
343-HD	DISPENSING STATUS	P or C	R	*P= Partial C=Completion*
344-HF	QUANTITY INTENDED TO BE DISPENSED		R	*Must be present and > Ø if 343-HD = P or C*
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		R	*Must be present and > Ø if 343-HD = P or C*
357-NV	DELAY REASON CODE		O	
391-MT	PATIENT ASSIGNMENT INDICATOR (DIRECT MEMBER REIMBURSEMENT INDICATOR)		O	
995-E2	ROUTE OF ADMINISTRATION		M	
996-G1	COMPOUND TYPE		O	
147-U7	PHARMACY SERVICE TYPE		R	*Retail: Ø1* *Home Infusion: Ø3* *Long Term Care: Ø5*

Pricing Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent	X			
	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	INGREDIENT COST SUBMITTED		R	Must be present
412-DC	DISPENSING FEE SUBMITTED		R	
433-DX	PATIENT PAID AMOUNT SUBMITTED		R	
438-E3	INCENTIVE AMOUNT SUBMITTED		R	
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	R	
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		R	
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED		R	
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		O	
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		O	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		O	Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		O	Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		R	

Pharmacy Provider Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*	
This Segment is always sent			
This Segment is situational			

	Pharmacy Provider Segment Segment Identification (111-AM) = "Ø2"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
465-EY	PROVIDER ID QUALIFIER		R	
444-E9	PROVIDER ID		R	*NPI Required*

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*	
This Segment is always sent	Y		
This Segment is situational			

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	Ø1	R	01- National Provider Identifier (NPI) submitted
411-DB	PRESCRIBER ID		R	*NPI must be 1Ø digits*
427-DR	PRESCRIBER LAST NAME		O	
498-PM	PRESCRIBER PHONE NUMBER		O	*If present, must be 1Ø-digit numeric*
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER		O	
421-DL	PRIMARY CARE PROVIDER ID	Ø1	O	*If present, value must = Ø1*
47Ø-4E	PRIMARY CARE PROVIDER LAST NAME		O	*Imp Guide:* Required if this field is used as an alternative for Primary Care Provider ID (421-DL) when ID is not known. Required if needed for Primary Care Provider ID (421-DL) validation/clarification.
364-2J	PRESCRIBER FIRST NAME		O	
365-2K	PRESCRIBER STREET ADDRESS		O	
366-2M	PRESCRIBER CITY ADDRESS		O	
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS		O	*Two-digit character state codes*
368-2P	PRESCRIBER ZIP/POSTAL ZONE		O	If 368-2P is present, ZIP code must be a valid 5 or 9-digit USPS ZIP code, must not include hyphens or all zeros in position 6 through 9

Prescryptive Health D.0 Payer Sheet
Prescryptive Pricing

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent				
This Segment is situational	R	Required only for secondary, tertiary, etc. claims.		
Scenario 1 - Other Payer Amount Paid Repetitions Only				
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only	R	OPPRA – (Scenario 2) - OCC of 8 and 3 – Copay Only		
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)				
	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing/Claim Rebill** Scenario 2- Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	1-9	S	
338-5C	OTHER PAYER COVERAGE TYPE		M	Must be present with Value = 01-09
339-6C	OTHER PAYER ID QUALIFIER		R	*If 338-5C is populated then values = Ø1, Ø2, Ø3,Ø4, Ø5, 1C, 1D, 99*
34Ø-7C	OTHER PAYER ID		S	Must be populated with Other Payer ID
443-E8	OTHER PAYER DATE		S	Must be populated with Other Payer ID
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	S	Must be present when 472-6E is populated
472-6E	OTHER PAYER REJECT CODE		S	
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	S	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		S	
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		S	
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.		
393-MV	BENEFIT STAGE QUALIFIER	01,02,03,04,05,61,62,70,80,90	S	Must be present when 394-MW is use
394-MW	BENEFIT STAGE AMOUNT		S	*Must be present with 393-MV is used* Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs.

Workers' Compensation Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational		

DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent				
This Segment is situational				
	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	1-9	R	
439-E4	REASON FOR SERVICE CODE		R	
44Ø-E5	PROFESSIONAL SERVICE CODE		R	Submit MA when provider billing Vaccine Admin Fees

441-E6	RESULT OF SERVICE CODE		R	
474-8E	DUR/PPS LEVEL OF EFFORT		O	
475-J9	DUR CO-AGENT ID QUALIFIER		R	
476-H6	DUR CO-AGENT ID		R	Required if this field affects payment for or documentation of professional pharmacy service.

Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*			
This Segment is always sent	Y				
This Segment is situational					
	Compound Segment **Segment Identification (111-AM) = "1Ø"**				**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*		*Payer Usage*	*Payer Situation*
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE			M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR			M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients		M	
488-RE	COMPOUND PRODUCT ID QUALIFIER			M	
489-TE	COMPOUND PRODUCT ID			M	
448-ED	COMPOUND INGREDIENT QUANTITY			M	
449-EE	COMPOUND INGREDIENT DRUG COST			M	*Must be present*
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION			M	
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Maximum count of 1Ø.		M	
363-2H	COMPOUND INGREDIENT MODIFIER CODE			M	

CLAIM REVERSAL TRANSACTION

The following lists the segments and fields in a Claim Reversal Transaction for the NCPDP Telecommunication Standard Implementation Guide Version D.Ø.

Reversal Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	Y	
This Segment is situational		

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill **If Situational, Payer Situation**			
This Segment is always sent	X				
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued					
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued					
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used					
	Transaction Header Segment				**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*		*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	BIN: 026944		M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ		M	
1Ø3-A3	TRANSACTION CODE	B2		M	B2= Reversal
1Ø4-A4	PROCESSOR CONTROL NUMBER	SEE ABOVE		M	
1Ø9-A9	TRANSACTION COUNT	1		M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01		M	
2Ø1-B1	SERVICE PROVIDER ID			M	

4Ø1-D1	DATE OF SERVICE		M	YYYMMDD
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Specify how this field is used, if not blanks.	M	

Insurance Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent	X			
	Insurance Segment **Segment Identification (111-AM) = "Ø4"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	
3Ø1-C1	GROUP ID		R	

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent	X			
This payer supports partial fills				
This payer does not support partial fills				
	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
4Ø3-D3	FILL NUMBER	0, 1-99	R	The values defined for this field are 0= Original fill, and 1-99 refill
3Ø8-C8	OTHER COVERAGE CODE	00,01,02,03,04,08	R	
147-U7	PHARMACY SERVICE TYPE		R	*Retail: 01* *Home Infusion: 03* *Long Term Care: 05*

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is situational	R	Required only for secondary, tertiary, etc. claims.		
	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	1-9	S	
338-5C	OTHER PAYER COVERAGE TYPE		M	Must be present with Value = 01-09